# The Canadian University and the Canadian School of Nursing

By EDITH KATHLEEN RUSSELL, B.A.,
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Within the last decade the nursing profession of Canada has set itself a new problem in the schools which it has established within certain of the universities of the country. From Halifax to Vancouver these schools for nurses have been started, one after the other in quick succession until seven at least of our universities have created regular teaching departments of this kind. I want to make clear that the argument of this paper starts from the fact that this connection between the nursing schools and the universities has already been effected. It is no part of my purpose to apologize for this relationship, to urge it or to decry it. We start from the accomplished fact, assuming for the purpose of argument—and with the support of reasonable evidence—that the new relationship is desirable and that it is destined to be lasting. However, while we may assert the existence of the nursing school within the university, we must at the same time recognize that this type of school is very new and it is evident that the nursing profession has now, of necessity, to make a most painstaking effort to discover what is to be the reasonable development thereof.

During these same years that this new type of nursing school has been establishing itself in our own country, a like development has been occurring elsewhere, and of especial interest to us are the happenings in this regard in England and in the United States. We find, as we would expect, that England has been conservative in this matter but that certain universities there have established some work of this kind. In the United States, on the other hand, the development of these university schools of nursing has been noticeably rapid and many of these have already taken form. The Canadian group finds itself, as always, somewhere between these two extremes, that is less conservative than England, less radical than the United States. There is at present considerable interchange of thought and counsel between the three groups; in fact a very happy camaraderie has been established of late between the leaders in the nursing profession of these three countries (made possible, largely, by the system of travelling fellowships established by the Rockefeller Foundation), a camaraderie that bids fair to widen the vision and thereby to increase the usefulness of all. It is indeed very far from my wish to decry this interchange of thought for, as I have already suggested, it is of the very greatest advantage to us. Having made this clear so that there can surely be no question of misunderstanding, I want to pass to another aspect of my subject and to consider the Canadian university school of nursing in the matter of the national aspects of our problem.

The nursing profession in Canada has asked for the establishment of these nursing schools within our universities and the request has been granted. At the same time a curious thing has happened. So far we have failed to recognize that the granting of our request by the universities has laid upon us an obligation *to study and to understand the universities of*

*Canada*, to understand the organization, the standards, the ideals, the peculiar characteristics which mark the growth of the university within our own country. The nursing school of Canada must accommodate itself to the Canadian university if it wants to work with it. This is the main burden of my argument and it will stand a lot of repetition. Nor can we accommodate until we know our universities. It may seem passing strange that such a self-evident fact should require enunciation. But there is no doubt about the need for this. After a good deal of attempt at discussion concerning these university schools I have discovered that the argument is usually a tangled one. What we have been trying to discuss is the organization of Canadian schools for nurses in terms of the American university; and this because much of our special experience in this regard has come from the United States. Such confusion of thought will bring us naught but confused results. I hope that there cannot be the slightest possibility of anyone interpreting these statements as containing any criticism whatsoever of the American university. Such argument is quite beside our present point. For the present argument it does not matter whether the Canadian university is as good or less good, whether it is better than the American or worse. My contention is that, whatever its character, we, as Canadian nurses, must know it. Surely, at this stage of our association with it, we are not going to attempt to alter our university system. It is enough that we accomplish our immediate task of creating our university nursing schools. Later when we have become a part of our country's universities we can hope to take our part (small though it may be) in the general development of the whole institution. At present, I would repeat once more, we must know our university and use it *as it is*.

Certain concrete examples should help to make the general argument more intelligible. What is the purpose of planning a nursing school in the university in relation to a general B.Sc. degree if there be no such degree within that institution? We surely do not wish to take responsibility at present for altering the whole policy of any one of our universities with regard to this matter. Again, why discuss the possibilities of a university nursing course so organized that it depends upon the credit and point system for earning a degree, when in many, or even most, of the Canadian universities there is no such credit system? Why discuss the possibilities for degree work for nurses unless we have some understanding of the whole structure of the pass and honour course system that is characterizing the present development of the Canadian university, and the difference of organization thus brought about from the organization of universities where professional schools are the dominant influence? Again may I repeat that our immediate task is not so much to exercise a critical judgment upon what is good or what is bad in our university development; it is rather that we shall first know and understand this university development; and also that we shall know and understand the influences that have brought it about. This is not too much to ask of any Canadian, for the general educational policy of the country should be a matter of vital interest to all.

Much of the discussion concerning the development of the nursing school within the university is fixed upon the question of the degree that is to be earned therein: this, though a side issue of the main problem, has become a very important question of late and demands special consideration. I know that I am sometimes quoted as being opposed to university degrees for nurses. Unfortunately the matter is not as simple as

that. One cannot be either in favour of, or opposed to, degrees in vacuo. Such a statement has no meaning. It is the conditions under which the degree is to be earned that may merit either favour or disfavour as the case may be. Around the question of degree granting a great deal of controversy is raging, and some unnecessary confusion has been introduced into the argument. There are certain indisputable points that can be separated from the controversial and thus our exact problem may be made very much clearer. First then we must recognize that a degree in itself has no value, it has no form nor beauty nor substance; it is merely a symbol and will have value only as it represents something definite to the world. Traditionally it has had that meaning, for it has represented a certain extent of scholarship. Of late years a demand has grown up for the conferring of degrees for other forms of attainment and, in some universities, the degree is now given in recognition of these various forms of attainment. Thus in some places the degree may mark, indiscriminately, success in scholarship or success in certain skills and arts, sans scholarship. It is no part of this present argument to prove that this is a good or a bad development, it is merely a statement of fact that I am making. Where the degree is given for attainment other than scholarship, it no longer denotes scholarship. We cannot make the situation other than thus. We cannot, at one and the same time, have two contradictory states of affairs. If the meaning of the degree is changed, it cannot at the same time retain its original meaning. Thus to the world at large today, a university degree has, in and of itself, no special significance. It is not until the source of the degree is stated that recognition is granted and sometimes this recognition is of a minus quantity.

Thus the affair stands. We ask for a new degree in nursing or for one of the older degrees of arts or science to be conferred in recognition of a four or a five year course in nursing. It may be that we are not quite sure as to why we want the degree, but surely it must be because we imagine it will confer some honour or prestige or that it will open the door to some desired preferment. While trying to get it, we must recognize one fact and that is that a degree thus earned (i.e., through the b a s i c nursing course) cannot retain the original meaning of scholarship and that, having lost the original meaning, it can have no specific significance until we have invested it with a new meaning. Such a degree *for the present at least* is an empty honour. No amount of argument can alter that fact. Such a degree *as a degree* has nothing but a local value.

There is a further fact that should be recognized in our effort to separate the controversial from the non-controversial points in this argument. If the nursing school insists upon earning a degree, it must be prepared to sacrifice some of the content that would otherwise be placed within its course and to yield that place to material of more remote relationship to its immediate objective. There is no possibility of denying this fact. Even the most easy-going university on this continent has set a minimum outline for each of its degree courses and this outline contains work that is not of first importance in the nurse's course, that is work that would not otherwise be given the preference there. Thus when a degree course for nurses is arranged, that course is dominated by the degree requirements and not by the exact requirements of this particular student (i.e., the nurse-in-training). This may not be regarded as a bad state of affairs. It may be that the compensations are deemed to be more than equal to the loss. Such arguments must be considered and doubtless opinions thereon will vary. Meanwhile note that this is a ques-

tion, not of value alone, but of relative values, and the fact remains that the degree does complicate the curriculum and exacts a compromise affecting both content and method. It is quite true that nurses are not alone in facing this consideration of compromise for many other professional groups must reckon with the same situation. But it may be the nursing profession will have to make an individual decision upon this matter, for is it not true that already in itself, the nursing school faces the most strangely complicated educational programme that has ever been undertaken? Is there any other school where the pupil, from the first day to the last of her training, is carrying in her hands the lives of her fellow men? Does this not mark off the nursing school as different from any other? Concerning the matter of differences a curious situation obtains today. There is a great urge to gloss over all distinctions between nursing schools and others, and at the same time to emphasize all possible similarities. The reason for this tendency is not hard to find if we know a little of nursing history and understand the intolerable conditions under which nursing schools (so-called) have laboured, but great care must be taken today or we may only go from one intolerable condition to another equally unmanageable. And, in the present confusion of thought, let us hope that we shall not try to level away all distinction between our schools and others. Can we not find reason to cherish these really magnificent differences and to realize that there is nothing in the English word "different" that implies inferiority—another indisputable fact to add to our list!

There is a further fact, the recognition of which should be of great service to us. In this discussion of the degree question, it would almost appear that nurses believe that they have a problem all their own. Such is not the case, however, and if we have ears to hear we shall soon learn that this matter of degree-seeking is a general tendency of the present day and one that is provoking much thought and no little alarm. A sister profession has been just in advance of us in yielding to the great glamour of these symbols. Many leaders in the teaching profession are today looking on with horror while its young members are madly pursuing degrees. The summer schools of some universities are filled with ardent young pedagogues, and everywhere the one all-important subject is being discussed by them: how can they, in the shortest possible space of time, add together the necessary credits to earn this or that degree? Seldom is there mention of the pursuit of scholarship for its own sake. Such a state of affairs is somewhat alarming. Thinking of this, I am reminded of an inquiry that came to our own school not long ago. It was a letter from a young nurse, seriously meant and quite unconscious of its own humour. The writer naively asked if I could help her with advice about studies that would earn for her a degree and at the same time give her some of the subject matter that she really wanted!

Certain questions follow obviously upon the above conclusions. If the degree is of uncertain value, will it be worth our while *just at present*, to sacrifice anything of more certain value for it? Is it wise, at the present moment, to concentrate upon the degree or would it be better to ignore the degree, temporarily at least, and to concentrate upon the desired content and method for our nursing courses? These are questions with which the nursing profession must be prepared to wrestle and the chief purpose of my argument is to beg from the nurses of Canada a serious consideration of these in terms of our own country. We cannot be of service in international councils until we have set our own house in order.

# *Health Visitors in England*

*Matters connected with the administration of the Maternity and Child Welfare and other Acts directly concerning the work of Health Visitors*

By Dr. T. EUSTACE HILL, O.B.E., D.Hy., B.Sc.

[**Editor's Note:** The Canadian Nurse is indebted to Miss Ruby Hamilton in obtaining Dr. Hill's permission for the publication of the foregoing article. Dr. Hill is medical officer of health for Durham County Council, England. This address was given at a Conference on Matters Affecting the Work of Health Visitors, held in February, 1928, in London, under the auspices of the Women Sanitary Inspectors' and Health Visitors' Association. Miss Hamilton, assistant director of field nursing, Ontario Division, Canadian Red Cross, was awarded a Scholarship by the Canadian Red Cross Society for a year's study in Public Health Nursing, International Course for Nurses, Bedford College, London, England.]

I am glad to take a part in the discussion of this subject, as for more than 25 years I have been a strong advocate of the appointment of well qualified and experienced health visitors in connection with County Health Work.

I realized the valuable work they could carry out even before the first Notification of Births Act, which local authorities were authorized but not compelled to adopt, was passed in 1907, and the Durham County Council was one of the early Health Authorities to bring the Act into operation throughout the administrative county. As a matter of fact the Durham County Council immediately after the passing of the Notification of Births Act in 1907 approached the district sanitary authorities on the matter and urged them immediately to adopt the Act, but only one authority (Whickham Urban District) responded, and the County Council then selected four districts where the infant mortality rate had been excessively high and as an experiment undertook to appoint and pay a health visitor for each of the districts if the district sanitary authority would adopt the Act. This offer was accepted, and the Act was adopted in these four districts and health visitors were appointed by the County Council as early as 1909. The result was most satisfactory, for during the three following years the infant mortality rate in these districts was considerably less than the rate in the remainder of the county, though previously it had been persistently greatly in excess of that rate. My Council, subsequently to this successful experiment, again urged the district sanitary authorities to themselves adopt the Act and appoint health visitors, but generally they were met with a blank refusal, and in the end the County Council adopted the Act, with the sanction of the then Local Government Board, except in four districts where the district councils expressed their desire to administer it and appoint the necessary staff for that purpose. In 1915 an additional Notification of Births Act was passed making notification compulsory throughout the country, but in Durham the Act had been in operation since 1913 when a superintendent and 25 whole-time health visitors were appointed by the County Council. We have now 84 whole-time health visitors and also several giving part-time services.

It was this Act which first made possible the systematic supervision by trained officers of children in the early years of life and the giving of advice to their mothers, etc., as to their proper care and management.

Warwickshire was the first County Council to appoint health visitors in 1903, and I am not sure whether health visitors were appointed prior to that date by the sanitary authorities of our large urban areas.

Since the passing of the Maternity and Child Welfare Act, 1918, and regulations relating thereto, it has been possible for the authorities administering the Notification of Births Act to develop comprehensive schemes for safeguarding the health of nursing and expectant mothers and young children, and throughout the country advantage has been taken of these opportunities to a varying extent, and in consequence welfare centres, ante-natal centres, maternity homes, convalescent homes, and other activities have been provided, and large numbers of welfare medical officers, health visitors, and nurses appointed; while there have also sprung into existence many voluntary organizations which are doing valuable work in spite of considerable overlapping.

In opening this discussion, I have chiefly to deal with the position of the health visitor in relation to this Maternity and Child Welfare Act, and, I take it, also with the question as to whether the administration of this Act should be under the complete control of the responsible local authorities, and the officers discharging the duties of health visitors be appointed by, and directly responsible to, those authorities.

At the outset of my remarks, I wish to say that all my practical experience of the administration of the maternity and child welfare schemes has been limited to a county district (Durham) which in respect of maternity and child welfare has a population of 850,000, embracing 42 urban and rural districts, but I think it will be admitted that in a county district the difficulties of organizing a satisfactory scheme of maternity and child welfare are very much greater than in a large town or urban district of relatively much smaller area. In a county area many of the sanitary districts have too small a population to utilize fully the services of a whole-time health visitor, and the district authority, if it is responsible for maternity and child welfare, must either combine with other district authorities if they desire a whole-time health visitor, or they must utilize the part-time services of a district nurse, if there happens to be a district nursing association established in the district.

I am quite convinced that in a county district the County Council is the most satisfactory authority for carrying out maternity and child welfare schemes, except perhaps in the sanitary districts which are large enough to utilize full-time services of one or more health visitors. Apart from the question of expense and efficiency, a great advantage of a County Council being the maternity and child welfare authority is that uniformity of administration is most likely to be obtained, and I am quite satisfied that delegation of the work to voluntary organizations is not desirable either in the interests of efficiency or uniformity, or of the officers who have to carry out the necessary duties. In other words "the authority which pays the piper should call the tune."

As regards the officer who performs the duties of health visitor, I have had considerable experience both of health visitors appointed and controlled by the responsible authority and of those who perform these duties but are appointed by and responsible to a voluntary organization, and I am certain that it is desirable that the health visitor should be appointed and controlled by the Maternity and Child Welfare authority.

In the first place, in an up-to-date health department there are so many public health activities affecting health visitors, and the work is so full of detail and developing so rapidly, that no official or body who is not in the closest touch with the department can be fully efficient. In a large town one cannot conceive any advantage in utilizing as health visitors individuals who are not appointed and controlled by the Health Authority. In a county the only

usual alternative is the nurse appointed and controlled by the Nursing Associations, and to this arrangement I think there are many objections, which I will shortly summarize.

(1) The primary duty of the district nurse relates to treatment and cure rather than to the prevention of disease, and very largely her training has been with that object in view. Very many of them are not adequately trained in the public health work and social services required of the modern health visitor. The district nurse in her purely nursing duties acts very largely under the direction of the private medical attendant of the patient, and in the discharge of her public health work is likely to be guided by him or by the members of her Nursing Association rather than act on the instruction of the medical officer of the maternity and child welfare authority. This may, and does result often, in friction, and in any case it means dual control, which is objectionable.

(2) Where the district nurse acts as health visitor the duties must at times clash. She may be summoned to an urgent surgical or medical case just at the time when her services are required at a welfare centre, school inspection or school clinic, and on such occasion it is probable that the public service will suffer, and at any rate the position of the district nurse is a difficult one.

(3) The new Regulations of the Ministry of Health, which operate from next April [1928. Ed.], require such high and specialized qualifications of health visitors to be appointed after that date that very few district nurses will then be eligible for new appointments, and nursing organizations which at present provide the health visitor services will have the utmost difficulty in obtaining district nurses with the requisite health visitor qualifications.

(4) Experience suggests that where a district nurse also acts as health visitor in a county district her purely nursing duties have the first call on her services, and that especially when accidents or general illnesses are much in evidence the public health duties are neglected.

(5) The work of a health visitor appointed and controlled by a voluntary body is much more likely to be influenced by the religious and political views of that body or its individual members than is the case with a health visitor appointed by a local authority and controlled by a public health officer, who is unlikely to be influenced by the views held by his authority, however strong they may be.

(6) In order to avoid overlapping it is desirable that a health visitor should be responsible for the whole of the health work which can be undertaken by her in an area of sufficient size and population to occupy her full time. It is better that she should undertake not only home visiting in regard to mothers and infants, but also to school children and tuberculosis patients. She may with advantage also act as visitor under the Infant Life Protection Act, and attend at the infant welfare centre, school clinic and tuberculosis dispensary. In my County Health Department our health visitors carry out all these duties without friction and with efficiency. I think it will surely be agreed that a district nurse primarily appointed for other duties could not efficiently perform all these health duties.

(7) There are some health visitors' duties, such as head inspections at schools and the giving of evidence in police court proceedings, which many district nurses strongly object to undertake, more particularly as such duties are apt to prejudice their relationship with subscribers to their nursing associations.

(8) For various reasons, appointments under district nursing associations are usually less permanent than are those of whole-time health visitors

appointed by local authorities and continuity of the health work is interfered with and the public health duties are therefore less efficient.

(9) Although the conditions of service of a large proportion of the health visitors appointed and controlled by local authorities are unsatisfactory as regards salary, holiday, sick leave, superannuation, etc., their conditions of service are, generally speaking, more satisfactory than are those of district nurses, and in consequence better trained applicants, especially from the point of view of experience in public health work, are likely to be attracted to whole-time health visitor posts under local authorities.

Where the health visiting work of a district is undertaken by whole-time health visitors appointed by the local authority their relationship to the voluntary committees of welfare centres is important. No one appreciates more than I do the valuable services rendered by these voluntary committees, but in my opinion it is most undesirable that they should direct or control the health visitor. The control should be in the hands of the Medical Officer of Health, the Medical Officer of the centre, or the Superintendent Health Visitor, who are themselves under the administrative control of the Medical Officer of Health. At the same time there should be the most cordial co-operation between the voluntary committee and the health visitors, and my experience is that in the great majority of cases this does exist.

In sparsely populated rural areas the circumstances may be such that it may be expedient that the district nurse, if she be a fully trained nurse, should discharge the duties of health visitor, though even in such cases I should prefer the whole-time specially trained health visitor and provide her with the necessary transport facilities.

No doubt the grants made by local authorities to nursing associations, whose nurses undertake health visitor duties, are often of great assistance to these associations, but this should not have weight if the result is a less efficient health service.

I hope I have said enough to persuade my audience that the most efficient public health services required of health visitors are best provided by whole-time health visitors who are appointed by and directly controlled by a Public Health Authority, but in any case I trust my remarks will stimulate a full discussion of this important subject. This view is evidently held by most public health authorities, for the great majority of them, including even County Councils, have appointed whole-time health visitors rather than utilize the officers of voluntary organizations.

Before concluding, I should just like to suggest the importance of the provision of better facilities for the training of health visitors. In Durham Administrative County, where a high standard of qualifications for health visitors has been required for several years past, it was found almost impossible to obtain a sufficient number of candidates up to the required standard, although the salary and other conditions of service compare favourably with those of most other districts outside London. To meet this difficulty it was decided to attempt to provide local training for health visitors, and with the approval and financial support of the County Council, a Health Visitors Training Board was established, for which the Superintendent Health Visitor acted as secretary. The County Council agreed to sanction the training of ten health visitor students selected by the Board and to advance for a period of six months, the duration of the training period, one-half of the commencing salary of a health visitor on their permanent staff, on the understanding that on the termination of their training they would act as health visitors on the

county staff for a period of six months on half salary. This arrangement has now been in operation for three successive years and has proved a great success for it has provided the financial assistance during training, which is necessary to enable many students to undertake it. Moreover, the training provided has apparently been of a high standard, for there has been a very small percentage of failures at the examination qualifying the successful candidates for the certificate approved by the Minister of Health and the Board of Education. The loan students before entering for the training course must be fully trained nurses and must hold or undertake to obtain the C.M.B. Certificate. Trainees, other than loan students, are also accepted for training if there is compliance with the required conditions. During the six months subsequent to training the loan students undertake holiday duty for the permanent staff on annual leave, and a large proportion of them have been permanently appointed on the County Health Visitors Staff, while the remainder have had no difficulty in obtaining permanent health visitor posts in other districts. This winter it has been possible to provide a hostel in Durham City where a limited number of bedrooms are provided for the students as well as dining room, library and lecture room, and kitchen with caretaker. The permanent Health Visitor Staff and their friends have provided all the funds necessary for renting and equipping the hostel. The institution and success of the scheme is almost entirely due to the untiring efforts and organizing ability of our Superintendent Health Visitor, Miss Cooper Hodgson, who has also proved herself a most capable and successful Secretary of the Training Board.

In conclusion I should desire to emphasize a truism, and that is that the health visitor is one of the most important factors in the education of the public in the preservation of health and the prevention of disease, chiefly because of the advice and assistance they are able to give as regards personal hygiene in the homes of the people. Not so many years ago I was frequently asked, usually by educated people, what is the use of health visitors? Is that question ever asked now? I don't think so. Although their work should not be limited to maternity and child welfare, I entirely agree with Sir George Newman's statement in his last Annual Report (1926) that money expended on centres and on the provision of health visitors brings perhaps a greater return than any other form of maternity and child welfare expenditure.

*Durham County Health Visitors' Staff*

One superintendent, 2 assistant superintendents, 82 health visitors. Of these 84 officers: 48 are fully trained nurses; 67 hold the C.M.B. Certificate; 53 hold the H.V. Certificate of the Royal Sanitary Institute; 22 hold the Sanitary Inspector's Certificate of the Royal Sanitary Institute; 24 hold the Board of Education's Diploma; 14 hold the Ministry of Health Certificate.

Many of our health visitors hold other special qualifications in such matters as mental deficiency, fever hospital training, etc., while three hold the Social Science Diploma of the University of Edinburgh.

## *Impressions of the International Re-union of Nurses in Rome*

This meeting of nurses from several countries was notable as the first of its kind held in conjunction with a congress of medical men. The invitation was conveyed to the Ladies' Committee of the Italian Red Cross by the President of the Conference, Signor Paolucci. It took place under the patronage of the Queen of Italy. The President was the Marquesa Irene Di Targiani Giunti. The Duchess d'Aosta showed her interest by her presence at each session, as well as on two social occasions.

The Congress was formally opened in the Capitol on the morning of September 25th, when "Il Duce" Signor Mussolini and Signor Paolucci addressed the gathering. This was followed by a reception by the Governor of Rome, which enabled the visitors to see the wonderful collection of statuary in the Capitol Galleries.

The nurses' meeting was formally opened in the presence of the Duchess d'Aosta, by Signor Paolucci and others. This was followed by the first session, when the chair was taken by Miss Reimann, secretary of the International Council of Nurses. The subject was "Methods of Developing the Spirit of Observation in Nurses in respect to Scientific Teaching and Social Conditions." Papers were read by Mlles. Descovich and Bianchi, visiting nurses of the Italian Red Cross, and by Mlle. Augiola Morell, secretary-general of the Women's Fascisti. A discussion followed, in which Mlle. Chaptal (France) charmingly emphasised the necessity for real sympathy and understanding of the individual and his needs if powers of observation were to be developed to their highest degree. Miss K. L. Borne, Matron of Papworth Village Colony, gave an interesting account of the work at the Colony.

An exhibition illustrative of the work being done in various countries was opened by the Duchess d'Aosta; photographs, charts, plans and models filled a number of rooms; specimens of ward furniture; sterilizing and x-ray apparatus were also shown. On the following morning, Mrs. Bedford Fenwick in the chair, the subject was "Special Nurses: the Preparation — M o r a l, Technical, Scientific—required for Co-ordination of the Services in Sanatoria, Dispensaries, Factories, and in the Home." A paper had been prepared by Signorina Gubazuati in collaboration with Signorine Cantu, Sartori, and Quidette on "Visiting Nurses," giving general outlines of the duties of a nurse engaged in public health, and concluding with a list of the qualities needed. The writers expressed the opinion that even with natural aptitude and technical and scientific training, at least ten years' experience was necessary for this specialized work. Papers followed by Miss Isabel Macdonald (Tuberculosis, especially from the preventive point of view), and Miss Ritchie Thomson (who spoke of the anti-tuberculosis work being done in G l a s g o w). Mlle. Delagrange (France) spoke of the dangers of too much specialization, and pointed out the disturbance to a poor household when visited by a succession of specialist nurses. Was so much overlapping desirable in the interests of the people, and would not a good all-round nurse in charge of a small area achieve equally good results? Among those who took part in the discussion were Mrs. Lancelot Andrewes (who spoke of the gradual development of nursing work and made a graceful reference to the pleasure felt by the members of the reunion in visiting that wonderful city), Miss Powell, Miss Cattell and Miss Graham.

Miss Musson, speaking from the point of view of our responsibility for the training of nurses for service in different spheres of action, expressed the opinion that the best foundation was a good basic training in general nursing, to which specialized training could be added. She emphasized the need for well qualified teachers for the probationer nurse and especially for careful selection of ward sisters. She noted that some speakers had advocated ten years supervision for specialized nurses, but the economic factor must not be lost sight of when considering the length of training. Signorina Pilastimi exhibited a chart illustrating the training scheme of the Italian Red Cross. This session was followed by an address by Professor Sabatini, dealing with the nurse and the doctor from the point of view of the psychology of the Latin races.

In the evening the public health film was exhibited. The most important session was perhaps that on the morning of September 27th, when nurses were invited to take part in the third theme of the 6th Congress. The chief speaker was Dr. William Brand (London) and the subject was "Organization of Anti-tuberculosis Work in Rural Areas," and members of the nurses' reunion were present in large numbers. The interest taken in the subject was evidenced by the fact that no fewer than 48 medical men had put down their names to join in the discussion. As each had apparently come prepared with a paper which took ten minutes to read, few, if any, of the nurses were able to hear all. Not only Dr. Brand, but many other speakers emphasized the value of the trained nurses' work in the anti-tuberculosis campaign.

A conference especially interesting to the Italian nurses followed, on "Italian law relating to Compulsory Insurance against Tuberculosis."

At mid-day a wreath was placed on the Unknown Soldier's grave in the name of the National Council of Nurses of Great Britain. Many of the British nurses attended and saluted the memorial in Roman fashion after the wreath had been placed in position by Mrs. Bedford Fenwick. Shortly afterwards, nurses of the Italian Red Cross, headed by the Duchess d'Aosta, placed a wreath side by side with that from Great Britain. (The Nursing Times, October 20th, 1928.)

## *Red Cross Work in New Brunswick*

**By a Nurse**

Perhaps in Canada there are nurses who might like to hear a little bit about the work of the Junior Red Cross in New Brunswick. During the past summer it has fallen to my lot to visit many rather remote parts of the province, and wherever I went the work that was being done by the Junior Red Cross filled me with not only joy but a deep reverence for the organization that only a few short years ago was composed of a very small number of children grouped together in scattered parts of Canada to do war work, now an organization stretching like a mighty army all around the world, working for the health and healing of the nations, their motto, *Health, Citizenship and Service*, taking a foremost place in every rural district that has Junior Red Cross in its schools.

When speaking of the Red Cross with a Women's Institute member in one of the rural districts, she said: "The Junior Red Cross is the very best factor for good we have in our community: the children are fast becoming healthier and many of them will be citizens we will be proud of some day." She was quiet for a few moments, then added, "We could not do without it in our district; we will be quite willing to work for Red Cross

and raise money every month sooner than let Junior go. I cannot express in words what it does, as I am a woman who finds it hard to express myself, but," and a smile came into her eyes and spread over her face, "my little girl of eight can run her meetings and take part in organization work now better than I can do. Her father and I are watching the way the Junior Red Cross does the work. When the Juniors grow up they will be much more worth while than ever we could be who learned in the old way. Then think of the good they do! They learn to save, to help others; a spirit of unselfishness grows in them, slowly at first but unfolding like a lovely flower, until the child is in some unexplainable way made over into a little citizen one can be proud of. The work for the crippled children in this province is one we are all proud of. It does not seem to me quite right for any child today to be allowed to grow up handicapped for life when the great war gave such a wonderful amount of knowledge to the surgeons of the world. They are willing to co-operate with the Juniors in every way, are they not?"

—By Courtesy, Canadian Red Cross.

IN A HOSPITAL GARDEN

She was quite right, the medical profession in New Brunswick is most co-operative, giving of their best to help Junior work of this kind. More and more is the Junior Red Cross becoming a part of the life of New Brunswick, and one who stops in the busy rush of modern life to think about it sees a great future: a province made better physically and morally and, may I say spiritually too, by that subtle influence in the hearts of the little children, which will in time transform this old world of ours with a glory all its own, and "a little child shall lead them" will in truth be fulfilled,—Juniors of New Brunswick working with Juniors all over the world in one big brotherhood of service.

As I left that little village nestling among the hills of New Brunswick I felt that I had been privileged in being able to stop for a moment and hear from one woman what Junior meant. As I travelled on during the summer it came to me more and more that it was not in one place only but all over the province that the love for the Junior work was rooted, growing, and bearing fruit. Doctors and nurses all over the province willingly pay their tribute to the good work being done. And from this province by the sea goes out a Junior call for Service that will echo through the ages in memory of those who came not back from their great adventure.

# *Provincial Association Series---The Alberta Association of Registered Nurses*

By ELEANOR McPHEDRAN, Calgary, Alberta.

The Alberta Association of Registered Nurses is a comparatively young organization, earnestly endeavouring to solve some of the nursing problems of a comparatively sparse community. At the time of its formation, there were relatively few graduates of training schools belonging to the province and the movement was carried out mainly by graduates of eastern provinces who were domiciled here for the time being. Previous to its organization, local associations had been formed in Edmonton, Calgary, Medicine Hat and Lethbridge. The former two drew together and a committee was formed to interview the then minister of health, the late Hon. A. G. Mackay, who took a deep interest in the movement and assisted very materially in the drawing up of a constitution and bylaws to be presented to the legislature. Mr. Mackay personally sponsored the bill and used his influence to secure the passing thereof.

At this time the educational side was stressed, and acting on his advice, the new child was placed under the guardianship of the minister of education, and organization proceeded. This minister, however, found it somewhat of an alien child. It did not fit into the scheme of things educational as he knew them. He couldn't understand its curriculum or inspect its schools as he could the various schools and colleges of learning to which he was accustomed, and it was a bit of a nuisance in that department; so somewhat suddenly and without the consent or knowledge of the child it was transferred to the guardianship of the ministry of health. Again it found itself an alien. Finally in 1919 an amendment was passed by the legislature placing the nurses' association among other professional organizations under the control of the University of Alberta.

At this time an effort was made to increase the minimum preliminary standing of the student nurse to graduates of Grade X high school, but unsuccessfully. The members of the legislature definitely stated in the act that nurses who had attained Grade VIII standing might register *if otherwise qualified*. The control of standards of training, the fixing of the bed capacity of the hospital conducting a training school, whether general or affiliated, the classes, lectures and other factors making for efficiency, the course of study prescribed and the conduct of the examinations, were all left to the senate of the university. The Nurses' Association was given the same standing in university councils that other professions held by representation on the senate of the university. The first appointment was held by Miss Victoria I. Winslow, at that time superintendent of the Medicine Hat General Hospital. Since losing her from the province, the nurses have been represented by the writer. Their especial "chief" at the university is the Dean of the Medical Faculty, Dr. A. C. Rankin, who has always had a warm sympathy for the work.

Membership in the Association is perforce individual. In only four of the larger centres are there local organizations — Calgary, Edmonton, Medicine Hat and Lethbridge, and while these probably cover the majority of the nurses actively carrying on, quite a large percentage are scattered throughout the smaller towns and villages with no opportunity to identify themselves with any nurses' organization. It was felt that these should have identical

privileges with the members in the more thickly settled districts, so individual membership was decided on. It is difficult to bring together a full representation of the nurses, and conventions are held only once a year. The actual work is carried on through a council of seven members elected by ballot biennially. Balloting is conducted by mail and all active members of the Association have an opportunity to express a preference. Membership in this council is confined to active members of the Association resident in the province, though all members paying annual dues have the right to vote no matter where residing. Arrangement was made in the constitution whereby the nurse not actively engaged in nursing in the province might retain membership, but claim exemption from annual dues. On the resumption of active work in the province, she is expected to resume payment of fees or be suspended from membership. This covers the case of many married nurses living in the province, also nurses pursuing their activities elsewhere. The number claiming exemption added to those who lose interest in the work and cease communication with us is about equal to the number of new members registering each year, so that active membership remains about the same.

Since the time of taking over by the university, the Association has devoted inself to furthering the interests of nurses, both graduate and student. In accordance with the constitution of the Canadian Nurses Association, an effort has been made to carry on the work through the three branches: nursing education, public health and private duty.

The nursing education section is a comparatively small body, who have busied themselves in matters pertaining to the student nurse. During the past two years the curriculum of training schools has been revised somewhat, and a detailed statement of the courses and text books recommended distributed to the interested schools. In the first draft of 1919-20 the nurses, together with the committee, arranged a very flexible course of study which required only eighteen months of definite work, leaving the other eighteen months to be arranged at the discretion of the superintendent of the school. The new curriculum specifies more definitely the amount of time which the student is expected to spend in the various departments. We like to think that the course given here compares very favourably with those given in other provinces in Canada and also with those given in the country to the south of us. Examinations are held twice yearly under arrangements made by the university; they consist of practical and written papers. The examining board is appointed by the senate of the university in the same manner as are the examining boards of other affiliated bodies and the nurse members of this board predominate. Registration itself is arranged for by the Association, the university certificate giving each successful candidate the right to apply for registration.

Through the co-operation of the university, a beginning has been made on hospital inspection. Hospitals of long standing and of the required bed capacity have so far been accepted without inspection. Where there is any doubt about the hospital standards of a student applying for admission to the registration examination, the committee on admissions appoints two nurse members of the examining board to make an inspection, reporting on all the features required in a general or affiliated training school. To date one new hospital has been recognized as qualified to give a general training to students, two have been recognized as affiliated schools—with two years at parent school and one year at the Edmonton General Hos-

pital—and one which could not be accepted without affiliation is carrying on with a graduate nurse staff and lay help.

The university, endeavouring to be of still greater assistance, established in 1924 a five-year course leading to the degree of Bachelor of Science in Nursing. So far three graduates have received the degree, viz., Miss Agnes MacLeod, now of the University Hospital, Edmonton; Miss Frances Alexander, who has returned to her home in Japan, and Miss Annabel Raver, who is with the department of health in the Child Welfare Clinic at Medicine Hat. At present there are two students entering their second hospital year and two entering their first year. To date there are four applicants for the term opening in 1928. These numbers may seem small to the more densely populated provinces, but we are extremely proud of them.

At the request of the Association, refresher courses have been held annually for the past five years. These have been arranged by the university for that period between the closing of lectures and convocation. An endeavour to give a course of sufficient variety to be of interest and help to all classes of nurses has been made. Lectures in nursing practice, pediatrics, dietary work, pathology, psychology, hospital administration, etc., have been given by members of the hospital and university staffs. To give an added interest there have usually been included lectures on subjects outside the ordinary curriculum. Mr. D. A. Cameron's lectures on "Books and Reading" have been "feasts of good things full of marrow." The Association owes much to Miss McCammon, now Mrs. Allan of Montreal, and to Miss Fenwick, her successor, for the zeal and hard work with which these courses have been arranged, as well as to those who have taken of their leisure to help refresh us professionally, mentally and socially. That these courses have been appreciated is shown by the numbers attending. It was considered at the outset that an average attendance of twelve would make it worth while. Each year has brought an enrollment of forty to fifty, with interest well sustained throughout the course.

The public health nursing group has been quite active along its own lines. The very liberal policy of the government in preventive work and in district work in isolated areas has absorbed a goodly number. The Red Cross Society has its quota, and the cities have their contingents of school nurses. The Victorian Order of Nurses has its especial work, and all these make up a very progressive branch of the Association. It has been the aim of these different bodies to secure nurses with special training in public health work where possible, but so far the demand has exceeded the supply of such workers. Again the university has endeavoured to co-operate by giving a short course (four months) to several classes and by the putting on of refresher courses at such periods as the nurses could be brought in from the field. The present chairman of the public health committee of the Association is Miss Elizabeth Clark, superintendent of public health nurses for the provincial government. At her office at the Parliament Buildings has been placed a very complete library on public health work, which is available for all members of the section on request.

The private duty nurses of the province have so far found the difficulties in the way of organization insurmountable. Attempts have been made from time to time—at first under the leadership of Miss Kelly of Calgary, Mrs. Fulsher of Calgary, later under Miss Cooper of Edmonton—but distances are so great, the time of the average private duty nurse so uncertain, and the personnel

so changing, that a satisfactory and workable plan of action has not yet been developed.

Apart from these activities, conventions have been held annually since 1916. Miss V. Winslow, of Medicine Hat, held the office of president for the first six years; her place was taken by Mrs. K. Manson, Edmonton, 1922-24; followed by Miss McCammon of Edmonton, 1924-26; Miss B. Guernsey was elected 1926-28, but resigned during 1927 and her term of office was completed by Miss Macdonald, General Hospital, Calgary. The offices of secretary, treasurer and registrar have been combined. This position was first held by Miss McPhedran, Calgary; during her service overseas, by Mrs. Armstrong, of Edmonton, and later Miss Rutherford, of Calgary, took over the work, which was resumed by Miss McPhedran on her return. She resigned in 1926 and this work has since been carried on by Miss Elizabeth Clark, of Edmonton.

Since 1921 the conventions have been held conjointly with the Alberta Hospitals' Association. It is felt that these conventions are of mutual benefit. Nurses in small hospitals in the country are in this way able to attend both conventions, taking what is most useful from either programme on the first day, and on the second day, topics of common interest are discussed in conjoint sessions; each Association is thus insured a wider public. For some years the Alberta Municipal Hospitals' Association met with us, but feeling that their problems were more closely associated with the problems of the municipality, they have withdrawn. At this year's convention the Alberta Association of Public Health workers, which was formed last year, has cast in its lot with us.

The nurses have endeavoured at each convention to have some outstanding representative of the nursing profession to address the meetings, both at our own and at the conjoint sessions. Such prominent nurses as Miss Ethel Johns, Miss Jean Browne, Miss Helen Randal, Miss Mabel Gray, and Miss Knively, of the Social Service Department, Toronto General Hospital, have been with us, and last year we were fortunate in securing the executive secretary, Miss Jean Wilson. We feel that as an outcome of her visit, the nurses of Alberta have a clearer idea of the work of the National Association than it is possible to obtain from reading or hearing reports of delegates.

To encourage further study on the part of graduates of Alberta training schools, it was decided by the Association to offer a scholarship to be applied to post-graduate study. This award of $200 was first offered to the student taking the highest standing at the registration examination for the current year. The first student to take advantage of this was Miss Margaret Fraser, of the Royal Alexandra Hospital, Edmonton, who in the fall of 1921 entered Teachers' College, Columbia University, to take the instructor's course. There was some difficulty in the manner of awarding, as in this case, the scholarship sought the candidate. The distances to suitable schools made heavy inroads into the often too slender purse, and two awards have not been made. The scholarship, increased to $500, is now given on application biennially. The candidate must be a graduate of an Alberta training school. She must state what her academic and professional qualifications are and what course she intends to take. This year the award goes to Miss Mosely, graduate of Royal Alexandra Hospital, Edmonton, who hopes to proceed to McGill School of Nursing this autumn to take the teachers' course.

Much remains to be done in the future. Chief among the objects before us may be mentioned:

(a) The raising of the preliminary educational standard for students entering on a course of training.

(b) The establishment of annual inspection of all training schools for nurses in Alberta.

(c) The standardizing of records, text books and procedures for all training schools in the province.

(d) The encouragement of the idea of centralized teaching where there are two or more schools leading eventually to the establishment of a central school of nursing for preliminary training.

(e) The encouragement of post-graduate work for graduates for both public health and administrative and teaching work.

As we look back over the past twelve years, we feel that we have accomplished a good deal, but the rapid change in the outlook of the profession since the beginning of the century, shows us much yet to be accomplished.

—By courtesy G. Gauvin.

**NURSING SISTER JANET MARY WILLIAMSON, M.M.**

Nursing Sister Janet Mary Williamson is dead, having passed away in New York on Sunday, October 21st after a very short illness.

Miss Williamson was born in Grenville, Quebec, receiving her early education there, finishing later at the Ottawa Ladies' College.

Graduating from the Lady Stanley Institute for Training of Nurses, Ottawa, in 1912, the intervening years before the war were occupied with private duty nursing.

Her overseas experience, including as it did, service in Moore Barracks, No. 1 Canadian General and No. 7 Canadian General Hospitals, culminated in the awarding by His Majesty King George of the much coveted Military Medal. In this connection a telegram received from Miss Margaret Macdonald, former Matron-in-Chief of the C.A.M.N.S., on hearing of Miss Williamson's death, is of interest: "I much regret the death of our most distinguished Sister Williamson. Her death is a distinct loss to the profession to which she rendered such valuable service. The honours she gained were well merited and borne with great modesty."

On the termination of the war Miss Williamson was employed in the Military Hospital at Kingston, Ontario.

In 1920 she was appointed Assistant Superintendent of Nurses at the Strathcona Hospital, Ottawa. Here she contributed valuable assistance in the reorganization of the school of nursing then being undertaken. In January, 1927, she resigned to take post-graduate work at Columbia University, New York. At the time of her death she was engaged in private duty nursing in that city.

The funeral service, held at Grenville, Quebec, was largely attended by members of the medical and nursing professions in Ottawa. Many beautiful floral tributes were in evidence, including one from the following nursing sisters on behalf of the C.A.M.N.S.: Elizabeth Smellie, Margaret Brankin, Anna McNichol, Mabel Hamilton, Clare Latimer, Mildred Robertson, Bertha Hughes, Edith O'Reilly, M. F. Jackson, M. E. Stevenson, Ethel Bagnell, Dell McGregor, Mildred Ewing, H. B. McCallum (Mrs. R. H. Ellis), R. A. N. Grattan (Mrs. (Dr.) Young), A. N. McDermit (Mrs. Poulton), and Matron E. M. Charleson.

Kindly, cheerful, thoroughly likeable, possessed of an unusual degree of charm, and an all-saving sense of humour, hers was indeed a rich and generous nature. Those coming in contact with her received an impression of great capability, strength, tenderness and a deep and broad understanding. The memory of these things makes the sense of loss more poignant: loss to the profession of a staunch supporter of its best traditions and highest ideals, and to those who were privileged in knowing her intimately, of a warm and sincere friend.

# Department of Nursing Education

National Convener of Publication Committee, Nursing Education Section,
Miss CHRISTINA MACLEOD, General Hospital, Brandon, Man.

## *Development of Study Habits in the Student Group

By ELSIE ALLDER, Royal Victoria Hospital, Montreal.

The problem confronting the nurse educator is that she has in her classes, students whose education ranges from that of the immature student with two years high school to the more mature student with one or two years university work to her credit, and the university graduate. In the latter group the majority of the students have formed good study habits, and have entered the school of nursing because of its reputation as a school employing excellent educational methods. In the first group the students *may* have established good study habits but many of them have little or no realization of the amount of study necessary to keep up with the educational programme of the school. For these students we must find some means of creating an active interest in the class work in order that the group with higher education may not be held back.

One of the first things necessary to this end is to plan the daily schedule so that during the preliminary course two hours each day are set aside for supervised study. The instructor should spend some time in teaching methods of note taking, and should require that note books in each subject be handed in early in the course for criticism of the method of note taking employed by each student. All notes should be collected and criticized at the end of each series of lectures throughout the three years spent in the school. Students thus early acquire the habit of taking good notes and keeping them in good form and ready for future reference. They should be able to get the substance of the lectures given by members of the medical staff and should be able to do this without having to rewrite their notes. The instructor should also give a talk on "How to study" and should assign some reference reading on the subject. She may ask each student to supply herself with a copy of Whipple's "How to Study Efficiently," or may place a number of these books in the library for the students' use. She may ask each student to write a paper on "Habits of Study," giving her any aid she may require in the preparation of her paper.

Frequent tests should be given during the course of a series of lectures. The papers may be exchanged and corrected by the students. This enables the instructor to judge the work of the students and at the same time eliminates the labour of reading many papers. It also stimulates the student to systematically review work already learned.

A series of papers may be prepared and read by the students on one subject, such as psychology: the topic being assigned by the instructor and a certain period each week kept for the presentation of one or more papers. Or one hour each week during the preliminary course may be set aside for the presentation of five minute papers on a variety of subjects. For example, one student may discuss the physiology of the circulatory system, another may talk about

(*The four articles appearing in this Department were read at the Nursing Education Section, Canadian Nurses Association, General Meeting, 1928.)

the hygiene of this system, a third may give a paper on History of Nursing, taking the period during which the circulation of the blood was discovered by Harvey. A fourth paper might be on solutions given intravenously. The assignments for the month must be posted two weeks before the first papers are to be read. The students may use any available device for making their talks interesting and may consult the instructors regarding reference books. This plan has been successfully tried and the nurses find these periods helpful as reviews on various subjects, and also useful as practice periods in public speaking.

Miss Sarah White in an article in *The American Journal of Nursing* suggests the following device as helpful in securing student activity: "Making posters; giving student an opportunity to do some teaching, and helping her in her preparation for her class; the compiling of bibliographies when studying a subject such as Professional Problems; excursions, with the class divided into sections, sending them to a variety of places of interest to bring back reports; summaries at the end of class periods, one student summarizing a lecture or class and others checking the summary." Miss White says that "the instructor must have time to plan out each project and be ready to help the students if they require assistance in carrying out their work."

Such activities no doubt would stimulate the interest of our students, and some of them have been successfully used in our schools, but before the device or project method can be generally adopted some changes must take place in our system of instruction in nursing schools. The instructors find it difficult to teach the required curriculum in the hours allotted to them, the nurses have not the time to devote to this type of study and, outside of the preliminary class, the nurses still attend classes besides having eight hours ward duty and no time for study.

Perhaps when the committee appointed by the Canadian Medical and the Canadian Nurses Associations has completed its survey of existing conditions in training schools for nurses, a revision of the curriculum and an eight hour day which includes class and study periods may be one of the results of its study of nursing problems. Then the instructors may have time to carry out the more interesting methods of stimulating learning in the student group, and the students will not be too tired to carry out the work necessary on assigned projects nor feel that they are neglecting some other important part of their work.

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# *Clinical Teaching of Nurses*

## I

*As done at the Royal Victoria Montreal Maternity Hospital Training School for Nurses*

**By OLGA V. LILLY, Instructor.**

The first step in this method of teaching is taken when the preliminary class is given the day before the pupil nurse enters the training school.

As ours is a teaching hospital regular clinics for the medical students are held on an average of ten a week; these are given on patients in the out-door department, the wards, labour rooms, delivery rooms and the operating theatre. Here we take the opportunity of urging the new pupil to attend clinics as frequently as possible and endeavour to point out how her obstetrical experience may be vastly broadened through voluntary effort. In order that a record may be kept of the attendance, the

supervisors keep books in which the pupil registers her name at the close of each clinic. True, the teaching done in this instance is primarily for the benefit of the medical students, nevertheless, it is of inestimable value to the pupil nurse inasmuch as it is here that the medical student is given all of his practical instruction in obstetrics, and is taught the nursing as well as the medical care of these patients. The privilege, when relieved from duty, of visiting other wards in order to study a case of unusual interest, and of attending deliveries, is extended to the pupil nurse at the preliminary class and she again is urged to avail herself freely of the countless opportunities for bedside learning.

As at this first class we also teach the new pupil some of the hospital routines in the care of normal cases, a post-partum patient is brought in and a demonstration made upon her before the class.

Further clinical teaching is done in the wards, delivery rooms and nurseries. The care of the breasts, the application of binders, bathing the new-born infant and so forth are demonstrated upon a patient instead of a doll. Each pupil will demonstrate back under strict supervision for, at the very least, the first time.

Two of the doctor's lectures are given on "Pre-natal examination," and at these an ante-partum patient is brought to the lecture theatre. A complete external examination is made upon her before the class, the internal examination being illustrated by means of lantern slides.

Following these lectures two or three ward clinics are held solely for the pupil nurses. Ante-partum and post-partum patients are chosen, small groups of pupils are sent to each bedside. On the ante-partum patients they listen for the foetal heart, counting it, measure the height of the fundus, note any signs of pregnancy (such as will be found in the breasts), take the external pelvic measurements, try to diagnose the position and presentation of the foetus, and finally estimate the duration of pregnancy and forecast the date of delivery.

On the post-partum patients the breasts are examined, the height of the fundus measured, the lochia noted, and, without asking the patient, a guess made as to the number of days since delivery. The groups then exchange patients and compare notes. A doctor and the instructor go from group to group and verify or dispute the findings. The bedside notes and history sheet of each patient are consulted at the close of the clinic.

During the winter and summer holidays, as there are no clinics for the medical students, arrangements are made to give at least one clinic per week for the pupil nurses. These are given by members of the attending staff and occasionally by the senior internes, and are held on both mothers and babies.

The pre-natal clinics also are a regular source of teaching. Every nurse attends some of these during her course and learns to take the blood pressure, examine the urine and otherwise assist the doctor.

The instructor endeavours to keep informed of the admission of any patient of particular interest from the teaching standpoint and at classes will refer to the case. If advisable she arranges for the nurses from other wards to see the patient; in any event they will be permitted to study the bedside chart and in that way follow up the case.

During the past year we have succeeded in giving some of the pupil nurses the opportunity to nurse a mother from the time of admission until she is discharged; this includes the care of her baby. We feel that this is an ideal experience for the pupil nurse, and aim to give, in the near future, the same opportunity to all who enter our training school.

II

## *IN A SPECIAL WARD*

By EILEEN FLANAGAN,
Royal Victoria Hospital, Montreal.

We all know from personal experience in every day life that the things we actually have done ourselves are the things we feel we *can* do and do well. This fact is just as true in the training of nurses as in general life, for we have all known the greater confidence we have in ourselves after we have taken our "first case;" gotten ready for our "first blood transfusion" and so on.

No matter how many times a nurse has the symptoms and general appearance of a patient suffering from typhoid fever, pneumonia, or diabetic coma described to her in classroom, she never has the picture fully impressed on her mind until she actually has such a patient in front of her and has to look after him or her. We all feel that the more combined clinical teaching and practical nursing can be taught in the wards, the better; but we all know that this method requires a great deal of individual supervision on the part of the instructor, and a great deal more time on the part of the nurse-in-charge of a large ward, than in the majority of cases, she has to give. In a small ward such as a pædiatric or metabolism ward where, as a rule, the staff of nurses is greater in proportion to the number of patients than in a large general ward, clinical teaching in the ward is usually feasible. The following description is of a ward of fourteen (14) beds given up to diabetic, metabolic, and research cases. As a rule the majority of the patients are able to be up and about, therefore, not entailing as much routine nursing care as the usual hospital patient. To offset this saving of time, however, there are many tests, examinations and procedures which require time and detailed attention.

The staff consists of one graduate nurse, one graduate dietitian, four nurses-in-training on day duty, on the ward; one on night duty and two in the diet kitchen. The nurses-in-training spend either four or six weeks in the department, two weeks each on day duty, night duty, and the diet kitchen. The four week nurses do not have night duty. In this way each nurse gets a good idea of the twenty-four hour service on the ward. The nurses rank in seniority according to the time on the ward, each nurse changing her duties weekly.

The ward being located in a teaching hospital there are clinics for medical students two mornings a week for an hour and a half. The nurses are able to attend these classes and get their theoretical teaching in diabetes, with the patients and their records before them. Then, again, as the reason for hospitalizing diabetics is to teach them to look after themselves in the matter of diet, general care, insulin administration, and urinalysis, the patients have instructions every day in a classroom at a regular time. The classes are given by the doctor, nurse-in-charge and head dietitian, and the nurses attend with the patients, so that in addition to learning the work for themselves, they learn how to look after and teach diabetic patients.

The senior nurse on the ward accompanies the head nurse while making ward rounds with the visiting doctor and staff and is thus able to follow the progress of the patients from day to day, and to understand the rationale of the orders given. This is very necessary for the correct carrying out of the various experiments.

Each nurse is taught individually how to take blood pressure, give insulin, and other procedures, with the patient as a subject. The nurses in the diet kitchen know the patients for whom they are preparing the meals and the reasons for the various types of diet. Each nurse must work

out a satisfactory diet to given values and have it checked by the dietitian.

This scheme, as you can see, requires considerable time and attention on the part of the teaching staff of the ward, but the results obtained are very satisfactory, making the work worthwhile.

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## III

## *IN A SPECIAL HOSPITAL*

By CATHERINE ROBERTSON,
Instructor, Alexandra Hospital for Contagious Diseases, Montreal.

The Art of Nursing is so essentially the art of being able to perform certain acts efficiently, it follows that the more teaching given in the form of demonstration and bedside instruction the more capable the student will be. The needs of the patient come first, and frequently the student nurse, assigned the care of patients, does so with very little working knowledge of the actual condition present and treatments required.

This is one of the greatest needs found when the nurse has been taken from her usual environment — the medical and surgical wards—and has to take up duties in some special department or affiliated hospital. It is a debated point whether any preparation for some particular branch of nursing can be given before actual contact with the patient takes place. The ward work must go on as usual even though changes are made in the student personnel. Perhaps the day will come when the nursing service will allow for groups of nurses being given some intensive instruction for one or more days before being responsible for the care of patients; meantime an almost individual supervision and clinical instruction seems to be the practical solution. In teaching any subject, given as a short course, the correlating of class work and ward experience is most important, giving the student a more lasting knowledge in a form which will be retained for future use. To do this satisfactorily there must be the best co-operation between the instructor and head nurses. Repetition, one of the laws of learning, must be carried out with the required standard maintained, otherwise much valuable time and energy is lost in the teaching field.

Careful preparation is necessary to give clinical instruction its full value, taking the immediate needs of the student as the first consideration. For some entirely new procedure a demonstration must be complete and accurate and more interest is shown if an actual patient, under treatment, can be used. This gives an opportunity of emphasizing the principle involved and of later observing results. It has been found helpful, in maintaining standards, to have personal supervision of treatments given by students, and credits allowed as part of the report in practical work.

One necessary detail of this method is that all students be given the same opportunities for demonstration and practice. When the knowledge of the diseases treated has been given as a series of doctors' lectures, it is most helpful to have some organized ward discussion. Students are required to make morning and evening ward reports, which will include new patients. The supervisor can take one of these reports as a foundation, asking questions and pointing out details of the disease and treatments, thus in a few minutes the ward group can have theory and practice linked up, and observation of conditions found in patients should be more extensive and accurate.

When time allows, the case study method is productive in the association of cause and effect and should always include the social history and health habits, making a desirable approach and contact with the patient, and increasing the nurse's powers of observation.

# Department of Private Duty Nursing

National Convener of Publication Committee, Private Duty Section,
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## *Surgical Measures in the Treatment of Pulmonary Tuberculosis*

By Dr. L. C. FALLIS, Chief Clinician, Queen Alexandra Sanatorium, London, Ontario

[I am indebted to Dr. G. S. Jeffrey, recently of this Institution, for assistance in collecting the material of this article, as well as the one published in the November issue of The Canadian Nurse.]

For the purpose of this paper, the lungs may be compared to sponges. That is, they may at times, in certain diseases, become saturated with moisture and toxins, and again, when the proper force can be brought to bear upon them, this moisture, etc., may be squeezed out and expectorated. They lie in the thorax completely free and movable, with exception of the attachment at the root whence the large bronchi, blood vessels, etc., are admitted. They are each in a completely separate apartment, the partition being constituted by what we know as the mediastinum.

Each lung is encapsuled by a serous membrane known as the visceral layer of the pleura, which layer of pleura traverses the root of the lung and is then reflected back around the chest wall, as the parietal pleura. Thus, although when the lung is expanded, as is the case in health, the two layers of pleura are directly in contact, yet there exists, as in the case of an empty hot water bottle, a space which can be demonstrated when a force is applied between the layers and causes them to separate. This space is known as the "pleural space" or "pleural cavity," and it is here the fluid collects in pleurisy with effusion, the pus in empyema, and it is also here where the air is contained in pneumothorax.

A pneumothorax may be *accidental*, as in the case of a perforate wound of the chest wall.

*Artificial pneumothorax* is that arrived at by the voluntary induction of air or gas into the pleural space, with a definite purpose of causing compression of the lung.

*Spontaneous pneumothorax* is a fairly common occurrence in cases of tuberculosis. The condition is caused when a diseased area of lung ulcerates the visceral layer of the pleura and thus admits air to the pleural space from the lung itself. This is frequently of an extensive nature, in which case there is considerable shock, acute dyspnoea, and pain, etc. The onset of a spontaneous pneumothorax is quite occasionally the terminal factor in cases of advanced tuberculosis.

It is, of course, the artificial type of pneumonthorax with which we will deal chiefly.

As far back as one hundred years ago it was noted by certain physicians that should the patient recover from the shock and acuteness of the occurrence of a spontaneous pneumothorax, there was quite frequently a definite improvement in the general symptoms, and even in those days the induction of air artificially was considered. No one, however, cared to make the attempt until in the neighbourhood of 1890 an Italian physician, Forlanini by name, reported a number of cases in which he had been successful in causing an artificial compression of the lung and with considerable benefit to the patients. Towards the close of the nineteenth century the treatment was pioneered in America by the late Dr. John B. Murphy, of Chicago, and since that time there has been a very gradual but universal acceptance of the pro-

cedure throughout the world, until at present, in some clinics, as many as 25 per cent. to 30 per cent. or even more of those patients admitted to sanatoria are treated in this manner, and it is to-day considered to be the greatest boon that has ever been instituted for the help of an advanced case of pulmonary tuberculosis.

The benefit derived by this method may be considered to be due only partly to the mechanical effect of causing compression of the lung and thus putting it at rest. The squeezing from it of the toxic mucous and caseous material, and the bringing together of the walls of cavities, are, of course, important results of the compression. But there is also another factor that enters into the picture, which is that of absorption. When the lung is compressed, there is also compression of the blood vessels and lymph channels, and as it is by way of the lymph flow the toxins are emptied into the blood stream, one can readily see that when a lung is under collapse there is every probability of toxaemia, and, in favourable cases, a complete cessation of constitutional symptoms. Improvement may be marked within a few days of the commencement of treatment, i.e., temperature falling, or even normal, and decrease in cough with a general feeling of well-being. The sputum is probably increased for a few days, after which one hopes for a marked lessening.

The ideal case for pneumothorax treatment would be one in which the disease was limited entirely to one lung. Unfortunately, such cases practically never occur. When one lung is collapsed the other lung must do the work of the two, and any disease which it contains would appear to be put at a considerable disadvantage in healing. As a matter of fact, the relief from toxaemia which the system experiences when the bad lung is collapsed may more than compensate for the added work which the good lung must do, and healing may actually proceed in the functioning lung. No patient would ever be selected for pneumothorax treatment with anything like extensive disease in the good lung, unless such disease appeared to have undergone advanced healing, or unless the patient's outlook was so grave as to warrant taking a long chance with the hope of possible help. Two types of cases are commonly selected. The toxic febrile patient with free cough and expectoration, whose disease is limited largely to the one lung and who is not responding to bed rest. The advanced case who has improved to a certain degree under ordinary measures of treatment but whose ultimate outlook for a satisfactory result is remote, frequently because the presence of a large cavity in the bad lung maintains a persistent cough and expectoration or is the source of recurrent haemoptysis. Pneumothorax may also be attempted in suitable cases for the relief of a severe and uncontrollable cough or as an emergency measure in repeated, severe haemoptysis, and it is now recognized as the treatment offering the best chance of a favourable termination in cases of lung abscess.

Collapse of a lung, when once established, is usually maintained from two to five years, frequently indefinitely. Some of the best authorities nowadays adopt as routine the discontinuing of the refills in the spring of the year following on two years' treatment. This, of course, only in cases where there are no untoward circumstances, contra-indicating such procedure. Artificial pneumothorax necessitates periodical refills for which the patient may find it necessary to visit a physician at some distance, and since there are, as well, complications to be reckoned with which we will discuss later, for these reasons it should never be undertaken lightly, nor before the ordinary measures of treatment have been given due consideration. While there are, no doubt, changes which occur in a

collapsed lung which render it less efficient as a respiratory organ, they rarely diminish its functioning power to any appreciable extent, and even after several years of collapse the lung may be allowed to re-expand and return to function. Many patients with perfectly functioning pneumothorax are reluctant to ever permit re-expansion, as there is always the possibility that the disease may become reactivated, and when the lung has once completely re-expanded the two layers of the pleura tend to become adherent, so that re-collapse at a later date becomes more difficult or impossible. Complete collapse of one lung does not ordinarily occasion any discomfort nor any shortness of breath on ordinary exertion. Many patients are able to carry on at their vocation while still under treatment.

Complete collapse of the lung is never attempted at the first operation. In order to avoid the shock which follows a massive spontaneous collapse, the lung is collapsed gradually by a series of air injections extending over a period of one or two weeks, and frequently longer. When collapse is complete, gas need only be injected to replace that which is absorbed, and since the rate of absorption gradually decreases, the interval between injections or refills can be slowly increased. When well established, refills are frequently only required at monthly intervals.

The patient lies upon the table with the lung to be collapsed uppermost, a pillow beneath his waist so as to increase the width of the interspaces between the ribs. A local anaesthetic, such as novocaine, is all that is required. For the first filling a blunt needle may be used so as not to injure the lung. The needle is connected by means of rubber tubing to a U-shaped glass tube containing a column of water (the manometer). When the needle enters the pleural space, the suction causes the level of the fluid in the manometer to oscillate with respiration in a characteristic way. The operator relies upon the manometer to tell him when the needle is in communication with the pleural space, for then only is it safe to inject air; also, to keep him informed as to the pressure of the air within the space. The apparatus is so arranged that air can be injected under gentle pressure in measured quantities. The average refill will be anywhere from two hundred to eight hundred cubic centimeters of gas. To carry on pneumothorax treatment satisfactorily, frequent x-ray or fluoroscopic examinations must be made and a careful check on the state of the good lung maintained.

Pneumothorax treatment is by no means always clear sailing. In the first place, adhesions between the two layers of the pleura, resulting from previous pleurisy, may practically have obliterated the pleural space, rendering pneumothorax impossible, or may be such as to prevent anything more than a partial collapse. Weak adhesions may give way as treatment proceeds. It is never safe to predict without trial just how much collapse is likely to be obtained. In some cases, before complete collapse is obtained, the mediastinum or thoracic partition shifts under the pressure so as to interfere with the expansion of the good lung or with the action of the heart. In such cases one must be content with less pressure and a partial collapse only. One of the most common complications of pneumothorax treatment is pleurisy with effusion, occurring in at least fifty per cent. of cases at some time during the course of treatment. It is usually heralded by malaise, fever, and aching throughout the affected side. After a few days the patient may feel and hear the splash of the fluid as he moves about. When the acuteness subsides, the fluid in most cases slowly absorbs. At times aspiration may be necessary since the increased pressure causes shifting of the mediastinum. Fluid acts in the same way as air in maintaining com-

pression of the lung, but is less easily controlled. Sometimes the lung floats out in the fluid, forming adhesions to the chest wall, so that sooner or later the air pocket is lost. Only rarely effusion may terminate in empyema. Then there is always the possibility that active or spreading disease in the good lung may necessitate release of the collapsed lung. However, in spite of these apparent drawbacks, pneumothorax treatment has proven a very excellent measure. It has given health and healing to thousands for whom the outlook was otherwise gloomy or hopeless.

*Thoracoplastic Surgery.* When an effectual pneumothorax is impossible because of adhesions, or a previously satisfactory pneumothorax pocket is lost following effusion and formation of adhesions, it is sometimes advisable to attempt collapse of the lung by the more drastic measure of thoracoplastic surgery. The essential feature of such operations is the removal of a section from each of the ribs on the affected side, so that the chest sinks in and the lung is partially collapsed. Thoracoplasty is never done where a satisfactory pneumothorax is possible. The surgical risk is much greater than in pneumothorax, but when once successfully completed there is not the same tendency to complications. Moreover, the patient is not subjected to the annoyance of repeated minor operations occasioned by gas refills. The collapse is never complete, as is possible in pneumothorax, but for the degree of collapse obtained, thoracoplasty is probably more effectual. Since it is, however, a permanent affair, cases have to be selected with even greater care than for pneumothorax. Thoracoplastic surgery in the treatment of pulmonary tuberculosis is rapidly coming into more frequent use, and the results obtained are encouraging.

*Phrenicotomy.* The operation of phrenicotomy is occasionally done as an adjunct, either to a pneumothorax or a thoracoplasty. In this operation the phrenic nerve which controls the movements of the diaphragm of the affected side is severed as it passes downwards in the neck, with resulting paralysis of that half of the diaphragm. The paralyzed and relaxed half bellies upward into the thorax, permitting a much more effectual collapse than would otherwise be possible.

*Summary and Conclusions*

1. A pneumothorax may be *accidental*, as in the case of a perforate wound of the chest wall; *spontaneous*, as in the case of the rupture of the visceral layer of the pleura, which occurs in a number of cases of advanced pulmonary tuberculosis; or *artificial*, as instituted by the physician as a voluntary measure of treatment.

2. While the selected cases for artificial pneumothorax are those with a unilateral disease, it may be tried, and has been found very beneficial, in many cases with more or less trouble in both lungs. One, of course, usually much worse than the other and concluded to be the most likely source of the present breakdown. It may also be used in cases of repeated haemoptysis and in the treatment of lung abscess, as well as other respiratory affections.

3. Treatments in many cases are continued indefinitely, but some authorities at present adopt a routine of two years from the spring of the year, following the induction. After discontinuing the refills, the lung will expand and function.

4. Pleurisy with effusion is found to develop some time or other, in probably 50 per cent. of artificial pneumothorax cases. This is usually not a serious affair and in most cases reabsorbs without jeopardizing the patient's outlook for recovery.

5. In many cases, due to adherent pleura, it is impossible to find the pleural space and, therefore, artificial pneumothorax cannot be instituted. In some of these cases thoracoplasty would be advisable and should always be considered.

# Department of Public Health Nursing

National Convener of Publication Committee, Public Health Section,
Miss MARY MILLMAN, Department of Health, Toronto, Ont.

[We have been fortunate in receiving from Miss M. E. Misner a copy of her report made following her course of study of School Nursing in England, under the direction of the British College of Nurses. While in England Miss Misner and Miss P. Morrison, superintendent of nurses, McKellar Hospital, Fort William, were received as Fellows of the British College of Nurses.—Editor.]

By M. E. MISNER, R.R.C., F.B.C.N.

## I
## *SCHOOL HEALTH IN LONDON, ENGLAND*

The Education Act of 1921 follows upon and improves upon the Children's Act of 1908. By it every school: elementary, public, secondary, continuation, any school, the governing body of which receives payments out of any general fund, such other schools or educational institutions (not being elementary schools) as shall come under the Welch Intermediate Education Act, 1889, *shall have the duty* to provide for the medical inspection of their pupils, and the power to make such arrangements as may be sanctioned by the Minister of Health. All these schools throughout England mentioned *must* have medical inspection. The Minister of Health decides as to whether the local authorities employ *adequate* service. Any local educational authority not coming up to standard in medical service is advised of the fact and caused to remedy its fault. Aside from these schools mentioned (which all receive help from the Government), the local education authority for higher education may exercise like powers, whether aided by the Government or not, if so requested by the management of school.

Seven years previous to the passing of the Children's Act, however, London had appointed school nurses, the first one to be appointed starting her duties in 1901. At that time ringworm was very prevalent and accounted for such a large percentage of chronic absence from school that the nurse was appointed for the sole purpose of following it up. She was, in fact, known as the ringworm nurse. Her work since has been extended over a wide domain, but statistics, the evidence of one's own eyes, and the school nurses' experience, reveal still a prevalence of this disease and of pediculosis such as we in this country have never experienced.

Sir George Newman, Minister of Health, says that the obvious improvement in the condition of the children in the elementary schools during the past 20 years can be very largely ascribed to the quiet and unobtrusive, but steady and persistent labours of the school nurses.

By September, 1904, the School Board, and its successor, the Council, had appointed eleven nurses whose duties specifically included the supervision of personal hygiene in children. The nurses at that time worked under great difficulties as there was no explicit statutory sanction for dealing with conditions in face of much opposition from irate parents. By 1911, however, legislation had been brought to bear on the subject following offers of help and co-operation between Borough Councils, London County Councils and the people concerned. Cleansing stations had been set up by the Borough Councils as a result of the Cleansing of Persons Act, 1897. The London County Council had also itself set up three such stations in 1910 and it was at these three stations that arrange-

ments were made for the compulsory cleansing of children in accordance with the powers conferred on the Council by the Children's Act of 1908. By 1911, therefore, a fairly comprehensive scheme was in operation for practically the whole of London. Increasing attention had been given during the war years to the methods of cleansing, and in 1919 by collaboration of the Council's chemical and nursing staffs, a special preparation was brought into use and proved so successful that it was possible to cleanse the most verminous of heads at a single sitting. At the same time a special type of metal comb was introduced which was found to be extremely effective. Not only in this scheme of head and body cleansing was legislation brought down, but power was given to the Borough Councils for cleansing, purifying or destroying articles certified as filthy, dangerous or unwholesome, and for the compelling of the stripping and cleansing of verminous dwellings. The cleansing scheme provides that local boroughs should be notified of all cases of children bodily infested and of persistent cases of head infestation. Thus, whilst the school child is being dealt with under the cleansing scheme, the local sanitary authority is given the opportunity of dealing with other members of the family, the bedding and clothing, and also with the actual dwelling. Extended powers in this regard were subsequently given in the General Powers Act of 1922.

Each cleansing station, by the way, is staffed by one nurse and two paid women attendants, who do nothing but cleanse heads. Tar oil is applied and left for five minutes and then washed out with soft soap and borax. The stations are equipped with every appliance: sprays, sinks, hot and cold water, bath tubs, showers, drying apparatus and towels. Parents attend during cleansing operations.

Miss Helen L. Pearce, F.B.C.N., superintendent of school nurses for London County Council, has her offices in the County Hall at Westminster Bridge. I spent a good deal of time with her at her offices, and from her I received a most valuable fund of information, not only of school nursing, but of the whole nursing situation in England. She has six assistants, one who does not go out of the office, and five who have supervision of the school work in groups of boroughs — there being twenty-eight boroughs. Each supervisor has about sixty nurses in her district, there being 328 nurses doing school work only. Each school nurse has 6,000 children to inspect, and these she sees at least every three months. During the time I spent with Miss Richardson, school nurse in Southwark, I did not see her examine any throats or backs of mouths at all, nor were the sleeves rolled up even. She seemed only to be looking for verminous heads and to be checking up on health habits. She stands facing a row of children, has a metal comb which she dips in a cup of lysol solution, and then runs through each child's hair, separating it to see if any nits or vermin are present. Nails and teeth are examined for cleanliness. She keeps no directory sheet. A general record of the names of children is kept in the office, but not carried on inspection. The name of any special case for immediate attention is given to the monitor, an older pupil, who puts it down in a note-book. In this book also the monitor keeps track of the classes as they come to the assembly hall, keeps boys in order, notifies each class when to come and records the nurse's verdict as to the cleanliness of the class. At a "Central" school such as this one I have in mind, only the boys who intend to go on to secondary schools attend, although there is an infants' school in the basement and a girls' school above, also in a separate building in the school yard an art and vocational department. Babies start at three years and enter

school proper at five. The nurse does not do follow-up work, although very anxious to do so. This part of the work is done entirely by voluntary, untrained workers employed by the Care Committee, with often unsatisfactory results. The nurse does eye-testing and weighing, but little classroom teaching of health.

One morning's work was inspecting 400 boys. Over in a corner of the great room was a table with about four boxes of penny sweets and a box of tooth brushes—all for sale to the pupils, a scheme for raising money for various sports activities or pictures, etc. Junior Red Cross is started with the infants. When they keep all health habits for a given time they are presented with a Junior Red Cross badge of which they are justly proud. Although the teacher does the greater part in bringing the children up to standard, only the nurse can pass them as being eligible for a badge. Loud are the wails of the child and bitter the complaints from parents if a child does not receive a badge. One child who once came up to standard and then lapsed from grace had the badge taken from him, of course, so mother and grandmother both came to school to protest. It was explained that it was not by coming clean just one day or two days that he could attain and retain his badge, but that he must always be clean and tidy. Some parents at first were suspicious of the nurse and teachers, fearing they meant to make gentlemen of their boys.

At some of the schools I sat and watched the School Medical Officer doing physical examinations and special inspections and going over "leavers." These "leavers" are boys who are stopping school at Easter to go to work—boys of 14, most of them looking small and young and undeveloped to be going out to work for the rest of their lives, but of course most of them come from underprivileged homes. The school master or mistress is always present during all health inspections by either the doctor or nurse, as is also the organizer of the Care Committee, who discusses with the parents there and then, ways and means of securing proper treatment for defects found. If the mother has no means of paying for private treatment a voucher is given her permitting her to take the child to a treatment Centre. Should the appointment not be kept the Care Committee representative calls to see why. If the parent does not attend the inspection the school nurse visits the mother with an advice card from the School Medical Officer, but any subsequent visits required are done through the Care Committee.

The routine for complete physical examinations by the School Medical Officer is when the child enters elementary school proper at the age of 5 years, then again at 8 years and again at 11 years. This is always done, but for "leavers" there is also another complete physical before actual leaving. In between these periods, of course, the nurse is making her quarterly inspections, and all children who appear to be not doing well are referred for a special examination. Thus, the children, although not receiving nearly so much attention from the nurse as we on this side give, receive a good deal more attention from the doctors. The dental staff make a complete survey once a year, with the exception of children who come up for medical inspection; for instance, each year the dentists examine all children under 5 and all between the ages of 5 and 8, and between 8 and 11, and over 11, but do not touch the children of those specified ages, because they will be examined by the doctor that year, and he looks at the teeth as well as all other physical parts of the child, so that every child is orally examined every year and medically examined at least four times in school life. In the majority of cases parents or guardians attend during the complete physical examination.

The provision for open air education for London includes at present 5 open air schools for tuberculous children with accommodation for 365 children, 8 open air schools for non-tuberculous children, and 137 open air classes in connection with ordinary open air schools, with accommodation for 5,480.

All the children attending these schools and classes go home each night to sleep and have Saturday and Sunday at home, the same as they do in our own open-air schools, but these schools remain open throughout the year. Then there are 5 country camp schools accommodating 484 children for short periods, providing for about 4,700 children annually.

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## II

### *BOROUGH HEALTH WORK*

### *The Borough of St. Marylebone*

Each borough of the county of London has its own Town Hall, its own administration in health, sanitation, etc., except for school nurses, who are employed and directed by the London County Council. The health visitors, and other nurses and helpers in the borough scheme have nothing whatever to do with school work, although the school nurses send their children to the borough cleansing stations and to the health treatment and dental clinics, conducted under the supervision of the Borough Council. There are six health visitors and sanitary inspectors, and two T.B. visitors. In 1926 these workers in the Borough of St. Marylebone, made 7,136 visits. Most of my health work was done and my observations made in this borough. As was their usual custom whenever I was entering a new field, the British College of Nurses made the way as smooth as possible for me, sending Miss Bartleet, an ex-member of the Marylebone Health Society to conduct me by taxi to the Town Hall. Dr. Porter, the Medical Officer of Health, received me most cordially and after a rather lengthy chat handed me over to Miss Mann, one of his very able health visitors, and Miss Baker, the tuberculosis nurse. The maternity and child welfare scheme now in existence, contains both voluntary and official elements, Marylebone Health Society being the greatest of the former. I spent some time at Queen Charlotte's Lying-in Hospital, and the Western General Dispensary, and the North Marylebone School of Mothercraft. This latter is in a very bad section and is doing a wide and splendid work. Clinics are held every day in the week. Infants' clinics every day. Toddlers' clinics every day, 2-5. Minor ailments clinics daily, where skin diseases, running ears, etc., are treated and circumcisions done. Sunlight treatments are given to mothers twice a week. The dental clinic is used for expectant mothers, as well as for pre-school and school children. A trained masseuse comes twice a week to treat rickety children. Anti-diphtheretic clinic for babies from the age of six months on. Here also ante and post natal consultations are held. On entering the general waiting room the first thing that caught my eye, was the neat way the clothes of toddlers were kept in wire baskets hung on the backs of the benches—for this was toddlers' day. It is thought advisable to hold the Toddlers' Clinic separate from the Infants' Clinic, because the baby gets all the attention when he is present, and the toddler is left in the background and too often allowed to slip back. I sat for an hour beside the toddlers' doctor. Little children with very distended tummies were brought to her. They were also suffering from diarrhoea. "Too many potatoes," said the doctor, and ordered suet dumplings, rabbit and fish. The fresh herring, she explained, were the richest in food value of any known food, but not out of the reach of the very poor. The dumplings are cooked, of

course, in meat juice or stew, and the suet supplies the necessary fat, as these people can afford little butter. Rabbit is the chief meat but has food value. Dripping is the usual butter. When necessary various kinds of cod-liver oil are given in hot milk. It was at this centre I met Dr. Mabel Brody, who was interested enough to give me a letter to Dr. Armande deLille of Paris, who in addition to being so great an authority on sunlight treatment, is also experimenting in anti measles work.

At the ante-natal clinic may be had pattern garments for expectant mothers and coming babies, the only charge being for the actual wool contained in the garment. There is also a free lending library, and a cup of tea for every woman attending.

Every woman who attends the ante-natal clinic, may come to the post-natal clinic and receive supervision for herself as long as she needs it and for the child up to the age of five years. Some drugs and some treatment are given. A summary of the physical condition of every child who attends the Infants' and Toddlers' Clinics, is sent to the school medical authorities. The school authorities notify the health worker of any infectious disease in the schools and the health worker visits the home, and, if necessary, can give the help of the district nurse in many cases free of charge. Doctors, hospitals, and midwives notify the M.O.H. of all births within 48 hours of birth. After ten days each infant is visited by the health visitor, who advises and then gives the address of the nearest and most suitable clinic, where the baby is then supposed to visit regularly until the age of 5 years. Arrangements for providing assistants in carrying out the work of the homes of expectant, nursing and ailing mothers, can also be made by health visitors. This is made possible by a grant set aside for the purpose by the Borough Council. If a husband's work is irregular, a grant of milk or dried foods can be obtained through the Ministry of Health, either free or at a reduced rate. A grant of milk is obtained for expectant mothers from the seventh month.

Ante-natal cases are found in various ways: 1, by health visitors making call for some other reason; 2, by certain hospitals sending lists of women they know to be pregnant. The hospital wishes the visitor to help the women prepare for their cases, to see the home conditions, and decide whether the home is a suitable place for the birth to take place in. If it is not the patient is taken to the infirmary or hospital, where she is expected to pay something. If the home is suitably clean and equipped, the hospital will probably send its own mid-wife. The Guardian or Almoner from the hospital visits to ascertain how much the patient can pay. Some ante-natal cases are discovered by the mother attending a clinic with a small child. She is in this event invited to the ante-natal clinic which is held once a week. These ante-natal cases are not visited in their homes, unless for a very special reason, but are urged to attend the clinics. If a woman is irregular in her attendance at the ante-natal clinic, a post-card is sent to remind her that her attendance is expected, but there are few delinquents. Some treatments, as well as abdominal belts, bandages, etc., are provided by the Council.

(The remainder of Miss Misner's report will be published in January, 1929, issue.)

# News Notes

## ALBERTA

CALGARY: The Calgary Association of Graduate Nurses held a very enjoyable bridge at the Colonel Belcher Hospital on October 16th. Forty tables were filled by the bridge enthusiasts. The Association is much indebted to Miss Allison and her staff of patients who very ably arranged the spacious recreation hall, and helped serve the refreshments. The sum of $50.00 was realized.

Miss Ash, local supervisor of the Victorian Order of Nurses, and her staff entertained in honour of Miss Nan McMann, western supervisor of the V.O.N. The various health and nursing departments were represented, and a most enjoyable evening was spent.

Miss A. Cartier, who has been engaged in private duty work for the past two years in San Francisco, is visiting friends in the city.

Miss J. Husband, who recently underwent a serious operation, is slowly recovering.

EDMONTON: Miss M. Baird gave an interesting talk on Prenatal Care at the October meeting of the Graduate Nurses Association.

The Kinsmen's Club of Edmonton are providing a nurse to work with the Tuberculosis Clinic. Miss Davidson, formerly of the Red Cross, has accepted the position.

Miss Stacey and Miss Story (University of Alberta Hospital, 1928), have accepted positions in the Westlock Hospital.

Miss Watherston, of the Provincial Health Department, is leaving for the old country on an extended vacation.

Miss Davidson entertained a few nurses at the McDonald Hotel in honour of Miss Nan McMann, western supervisor of the Victorian Order of Nurses.

The Graduate Nurses Association greatly regret the sudden death of Dr. H. R. Smith, superintendent of the Royal Alexandra Hospital.

## BRITISH COLUMBIA

The results of the recent examination held in many centres throughout British Columbia for the certificate and title of "Registered Nurse" are as follows: names being given in order of standing:

80% TO 100%—Misses E. Berry, St. Paul's Hospital, Vancouver; M. E. Harvey, Vancouver General Hospital; M. Thom, Vancouver General Hospital; (D. Heap, Royal Jubilee Hospital, Victoria, and F. MacKechnie, Vancouver General Hospital, equal); (A. Castell, Hazelton General Hospital, and M. E. Doyle, St. Paul's Hospital, Vancouver, equal).

70% TO 80%—Misses G. G. Davis, M. S. Tait, E. K. Gann, P. E. Lyons, Sister M. Beatrice, (M. J. G. Johnston and G. M. Spurr, equal), L. Crafter, (G. Underwood, H. Watt, equal), A. Lambert, C. G. Lang, E. Langlands, H. H. McIntosh, (M. A. Eyles, E. V. McFarlane, A. T. Yates, equal), (C. D. M. Beard, M. B. Garner, I. M. Lamont, equal), F. B. Floyd, M. Traquair, C. Moir, B. P. Clark, M. M. Pitts, E. A. Hampton, (C. A. M. Ross, I. K. Stewart, equal); (F. M. Crosby-Daly, D. E. Rowlands, equal), H. M. Guy, M. G. Lusk, J. E. Martin, (M. A. H. Cruickshank, M. B. Hardy, equal).

60% TO 70%—Misses S. I. Swanston, (M. E. Anderson and A. E. Leveque, equal), (Misses I. M. Lee and I. E. Otterbine, equal), A. M. Cook, B. L. Montague, (H. V. Cochrane, H. A. W. Fowler, equal), D. M. Edwards, (M. G. Brice and E. M. Cameron, equal), H. Nichol, (I. V. Malo and Sister M. Ethelreda, equal), E. M. Roome, (V. M. Milner and D. Watson, equal), M. E. Symons, (M. M. Banfield and C. C. Murray, equal), (A. M. Cumberland and J. L. Stoddart, equal), (K. A. Kennedy and V. Smith, equal), J. E. Calder, E. M. Lacombe, A. Wyrzykowski, (E. M. Ferguson and F. C. Main, equal), (Mrs. V. Needham and N. J. Ross, equal), M. A. Williams, D. F. C. Bayntun, (C. L. Flick, S. Z. Moore, equal), I. M. Reece, J. Down, T. Attewell, C. Deacon, E. S. Cronkite, E. R. Ross, J. Archer, Sister M. Fintan, D. Crystal.

PASSED SUPPLEMENTAL EXAMINATIONS—Misses V. Cloke, P. G. Edwards, J. Lockie, F. C. Mathews, E. Ruttan.

PASSED WITH SUPPLEMENTAL EXAMINATIONS TO WRITE—Misses C. M. Bawtinheimer (1), I. M. Dynes (1), E. Fiddick (1), D. Forde (1), C. M. Hardie (1), E. M. C. Jackson (1), B. Leonard (1), L. Morrison (2), C. F. McNichol (1), E. Simpson (1).

## MANITOBA

BRANDON: The first regular meeting of the Brandon Graduate Nurses Association for the season, was held at the home of Mrs. Bigelow. Doctor Bolton gave an instructive address on "Infantile Paralysis." A social time during which dainty refreshments were served brought a pleasant evening to a close.

Dr. A. C. Baragar, superintendent of the Brandon Mental Hospital, has gone overseas for eight months to take a post graduate course.

GENERAL HOSPITAL, WINNIPEG: Mrs. (Dr.) Stevenson (Martin, 1916), was a patient in the hospital recently.

Miss M. Macrae (1911), who spent the past three months in Scotland, is visiting friends in the city.

Miss J. Isabel Smith (1910), of Los Angeles, is visiting her mother in the city.

Miss Clara Gillies (1912), who spent the summer months in Winnipeg, has returned to New York.

Miss Gertrude Hall (1921), who has been very ill, is much improved.

The Alumnae gave a supper dance in the Fort Garry in October. Much credit is due Miss McGillvary and her committee for the success of this event.

## NEW BRUNSWICK

ST. JOHN: The meetings of the St. John Chapter of Registered Nurses, September and October, were marked by the large number of members present, September being the annual meeting, the election of officers for the coming year took place. The president is Miss E. J. Mitchell, unanimously re-elected; the vice-president, Mrs. J. Vaughan, and the second vice-president, Miss Kathleen Lawson. Miss M. Fraser, Miss E. J. Mitchell, and Miss A. Sutherland were re-elected to the offices of treasurer, registrar, Sick Nurses' Benefit Fund, Stamers Memorial Fund, and secretary, respectively. Others elected were: "The Canadian Nurse," Miss Thorne and Miss MacGillivray; Private Duty Section, Miss Lawson; Programme Committee, Miss Richardson, Miss E. McCarthy; Refreshments, Mrs. Burnham, Miss M. Murdock.

Miss Retallick, as delegate to the C.N.A. Biennial Meeting at Winnipeg, spoke of a very interesting visit she had paid to the publishing house of "The Canadian Nurse," urging the members to give loyal support to their own magazine.

The feature of the October meeting, a lecture by Dr. C. M. Kelly on spinal anaesthesia, was very interesting and instructive. The apparatus for spinal anaesthetics was demonstrated, also the spinal mercurial manometer. A hearty vote of thanks was extended to Dr. Kelly.

Mrs. Arthur Chesley (Beatrice Reid), received October 11th, 1928. A large number attended and a great many of the nurses were present.

Miss Lucy McIntosh has accepted a position on the staff of the Mount Kisa Hospital, New York City.

ST. JOHN INFIRMARY: The Alumnae of the St. John Infirmary held their annual meeting September 10th. Miss Mary Downing was elected president; Miss Mary Walsh, vice-president; Catherine MacGillivray, secretary; and Gertrude Ward, treasurer. Additional members of the executive are Miss Higgins, Miss Moore, and Miss Jennings.

## NOVA SCOTIA

ANTIGONISH: St. Martha's Hospital School of Nursing held its Commencement Exercises on the evening of September 4th.

The Reverend I. McLellan, president of the Board of Directors, occupied the chair.

After the overture, Miss Evelyn Kelly delivered the salutatary, a very pleasing contribution to a most enjoyable programme. This was followed by a chorus "Murmur Soft Ye Breezes," by the student nurses, after which the graduates solemnly spoke in unison the Florence Nightingale Pledge.

The chief feature of the evening was a masterful address by Right Reverend James Morrison, Bishop of Antigonish, who also presented the diplomas to the graduates as follows: Misses Edna Hurst, Mary E. Theriault, Frances Dick, Anna McKinnon, Margaret R. McDonald, Margaret Chisholm, Mary A. McDonald, Evelyn Kelly, A. Savage.

Mrs. R. F. McDonald and Miss Cecilia Chisholm presented the class pins.

W. F. McKinnon, M.D., F.A.C.G., on behalf of the medical staff, delivered an inspiring address to those who had, after three years of application and devotion, fitted themselves for one of the moblest of professions.

"Opportunities and Progress in the Field of Nursing" was the theme of a splendid essay by Miss Annita McDonald, a student nurse; after which Miss M. Chisholm, class valedictorian, spoke her fitting words of farewell.

## ONTARIO

Paid-up subscriptions to "The Canadian Nurse" for Ontario in November, 1928, were 1,173, 10 more than previous month.

### APPOINTMENTS

HAMILTON GENERAL HOSPITAL: Miss E. Menzies, who has been supervisor of the private wards, has been appointed supervisor of the maternity department.

Miss I. Buscombe (1921), has been appointed supervising instructor.

Miss J. Jackson (1927), as charge nurse of Ward 4.

Miss McDermott (1909), as supervisor of private wards.

HOSPITAL FOR SICK CHILDREN, TORONTO: Miss Amy Beare (1927), has accepted a position on the staff of the Children's Hospital at Detroit.

GRACE HOSPITAL, TORONTO: Miss Irene Gilbert (Grace Hospital, 1928), has been appointed to the Obstetrical Department of Grace Hospital.

Miss Myrtle Barobe (St. Joseph's Hospital, Port Arthur, 1927), has been appointed superintendent of the Isolation Hospital, Fort William.

Miss Vera Lovelace (McKellar Hospital, Fort William), has been appointed school nurse in Port Arthur.

### DISTRICT 1

WINDSOR: The Hotel-Dieu of St. Joseph has fifty pupil nurses, of whom fifteen entered this fall. Sister Teresa of the Infant Jesus is superintendent, and Miss M. Richards, assistant superintendent.

At the last monthly meeting of the Alumnae Association, of which Miss M. Finnegan is president, Dr. Raymond Morand gave an interesting paper on Fake Cures.

### DISTRICTS 2 AND 3

HANOVER: Miss Ada Graham who has been assistant superintendent of the Hanover Memorial Hospital for the past year has resigned and received an appointment on the staff of the Harper Hospital, Detroit. Her place has been taken by Miss Edith McDonagh (Hanover Memorial Hospital), of Owen Sound.

Miss Jessie Craigmill, Harriston (Hanover Memorial Hospital), resumed her duties on the staff of the University of Michigan Hospital, Ann Arbor.

### DISTRICT 4

HAMILTON GENERAL HOSPITAL: The Alumnae Association held a most successful

bazaar in the nurses' residence of the General Hospital on October 26th, 1928, the proceeds of which were in aid of the Mutual Benefit Association, in connection with the Alumnae. Mr. Paul Myler very generously donated a Westinghouse Batteryless Radio to be drawn for, the proceeds of which went far towards making the total amount of $1,355.86. Mr. Stuart Roy, husband of our worthy president, kindly donated a hypodermic set, and Miss Grace Hall a breakfast set, both articles to be drawn for.

Dr. and Mrs. Stokey (Sybil Hosking, 1922), of Africa, are home on furlough.

DISTRICT 5

HOSPITAL FOR SICK CHILDREN, TORONTO: The first meeting of the Alumnae Association for the year took place on October 11th at the Nurses' Residence. The president, Miss Hazel Hughes, occupied the chair. An exceptionally interesting report of the Biennial Meeting of the Canadian Nurses Association at Winnipeg, was read by Miss Fitzgerald, who had represented the Alumnae. Dr. F. N. G. Starr gave an interesting address on "Cancer."

A number of delightful chain teas are being given by various members of the Alumnae Association—Miss Hill, of Meadowvale; Miss Halliday, of Whitby; and Mrs. Dal Smith—all of which have proved both socially and financially successful.

The official opening of Thistledown, the new convalescent hospital of the Sick Children's, took place on October 24th, when hundreds of interested friends motored out to view the beautiful place, with its up-to-date equipment of every sort. Doctor Cody performed the opening ceremonies. Miss Alice Grindley (1914), is in charge, with Miss Sue Smythe (1917), as assistant.

WESTERN HOSPITAL, TORONTO: The monthly meeting of the Alumnae Association took place in the nurses' residence on October 9th. There was a large attendance. A new method of electing officers for the ensuing year was discussed.

Miss Bessie Hamilton and Miss Pinkerton (1924), are doing institutional work in the New York State Hospital.

Miss Mary McCamus (1920), has been awarded a scholarship by the Alumnae for one year's course in Teaching in Schools of Nurses, at the University of Toronto. In the November number of "The Canadian Nurse" it was incorrectly announced that Miss McCamus was taking a course in Public Health Nursing.

WESTON: The annual meeting of the Alumnae Association of the Connaught Training School for Nurses was held at the home of Miss Clara Foy, Toronto.

The secretary and treasurer presented very satisfactory reports. The president, Miss Hazel Dixon, read a list of the contributions received towards the "Annie Beauchamp Fund." It was decided that the sum of five dollars should be set aside to provide a prize for the graduating class.

DISTRICT 7

GENERAL HOSPITAL, KINGSTON: Miss Gertrude McCullough and Miss Gladys Lozier (1925), are doing general duty at Nyack, N.Y. Miss Mary Wheeler, night supervisor at K.G.H., and Miss Mildred Davis have returned from a month's trip to Billings, Montana.

DISTRICT 8

OTTAWA: The 1928 Graduating Class of the Ottawa Civic Hospital have contributed $25.00 out of their class funds to the International Congress Fund.

DISTRICT 9

TIMMINS: St. Mary's Hospital has opened its new seventy-five bed building, which is the first fire proof building to be erected in Timmins. A training school for nurses has also been opened, with accommodation for twenty nurses. Sister M. Fidelis is the director of nurses.

DISTRICT 10

The October meeting of District 10 was held in St. Joseph's Hospital, Port Arthur, with 26 nurses present. Dr. C. N. Laurie, Port Arthur, gave an interesting address on Infantile Paralysis. Arrangements were made for a Christmas bazaar. Two hundred dollars was voted for the International Congress of Nurses Fund. Following a musical programme a social hour was spent.

Miss Martha Racey (McKellar Hospital, 1928), is taking the course for nurse instructors at McGill University.

Miss Blanche Montpelier (McKellar Hospital, 1918), is taking a course in anaesthesia at Grace Hospital, Detroit.

Sister Frances, instructor of nurses at St. Joseph's Hospital, is taking the course for nurse instructors at the University of Toronto.

## QUEBEC

GENERAL HOSPITAL, MONTREAL: Miss Dorothy McRae (1927), fills the position of instructor at Medicine Hat General Hospital, Medicine Hat, Alta.

Misses Patricia Kenehan, Sadie McIsaac and Kathryn Brady (1927), are engaged on the staff of a hospital at New Rochelle, N.Y.

Misses Dorothy Brewster and Carrie Forbes (1927), have taken positions in the office of H. M. Little, M.D.

Several of the staff nurses of M.G.H. are taking part courses at McGill University this year.

Miss Ina Currie (1924), has resigned her position at Iroquois Falls, Ont., and is now doing private nursing in Montreal.

Misses Jean Van Vliet and Gertrude Cook (1922), and Flora Maroni (1927), visited Europe during the past summer.

Misses Ethel Cook and Evelyn Elliott (1928), are engaged in institutional work at Saranac Lake, N.Y.

The sympathy of the members is extended to Misses Annie MacFie, Agnes Jamieson, and Grace Carter, in the loss of their mothers recently.

Miss M. M. Pharaoh and Grace Blacklock have gone to Iroquois Falls, Ont., as charge and assistant nurses of the General Hospital there.

The engagement is announced of Martha Agnes, daughter of the late John W. Harris and of Mrs. Harris, of Burks Falls, Ont., to William Dickson Sumner, son of Mr. and Mrs. Frank Sumner, of Montreal. The marriage to take place quietly in January.

Miss M. K. Holt, superintendent of nurses, M.G.H., succeeded Miss M. Hersey, superintendent of nurses, R.V.H., as president of the Association of Registered Nurses, of the Province of Quebec, when the latter became president of the Canadian Nurses Association.

Mrs. Thomas Dennison (nee Peggy McLeod), of Montreal, has gone with her husband, to reside in Detroit, Mich.

Misses Amy Des Brisay, Frances Reed, Caroline Barrett and Mabel K. Holt, attended the quarterly meeting of Quebec Provincial Association, at Three Rivers, P.Q., in October.

Miss Clark, Mrs. Kierstead, and Miss Mary Mathewson, are each taking a course at McGill University in Training School Administration, Teaching in Schools of Nursing, and Public Health, respectively, besides four others already reported, who were awarded scholarships.

Miss Elizabeth Ross, M.A., R.R.C., has resigned as superintendent of Olean General Hospital, Olean, N.Y., to accept a position as director of nurses at the Graduate Hospital, University of Pennsylvania, Philadelphia, Penn.

M.G.H. nurses taken on staff of Women's General Hospital, Montreal, are: Misses Christena Denovan (1920), night superintendent, Helen Haselton (1927), ward supervisor, Mary Haister (1928), ward supervisor, Sadie Hicks (1928), charge of O.D. Dept., and Dorothy Coffrin (1928), general ward duty.

Dr. L. Rea, of the Pathological Dept. of M.G.H., gave a very interesting address on Carriage of Infection, at the October meeting of M.G.H.A.A., at the nurses residence. The November meeting took the form of a social evening.

Changes at M.G.H.: Misses Margaret Willis (1918), has joined the night staff of supervisors, Elizabeth Robertson (1923), a recent graduate of McGill University, has returned to the O.D. staff, Inez Welling (1923), charge of C and D floor, Edythe Ward (1923), supervisor of wards, Annie E. Cromwell (1925), charge of Ward L, Juana McCosh (1926), charge of Ward K, Martha MacDonald (1927), charge of Ward O, Louise Shepherd (1928), assistant superintendent's office, and Jessie Allport (1928), on the staff of S.O.R.

Royal Victoria Hospital, Montreal: Miss Claire Brigham, Miss C. Greene, and Miss Morgan (1928), have received staff appointments, Miss Brigham to Ross Operating Room; Miss Greene, 4th floor, Ross Pavilion, and Miss Morgan, Surgical Ward G.

Miss Helen Baynes (1902), is visiting in Vancouver and California.

Miss Hazel Macdonald and Miss Elizabeth Rogers (1927), are on the staff of the Women's Clinic, Royal Victoria Hospital.

Western Hospital, Montreal: The Alumnae Association this year offered a scholarship of five hundred dollars to a graduate of the Western Hospital, to permit her to attend the School for Graduate Nurses, McGill University. Vernie Kerr made application and has been awarded the scholarship. At the November meeting a letter of acknowledgement and thanks from Miss Kerr was read, in which she stated that she had decided to take the course in administration in schools of nursing.

At the October meeting Miss Marion Nash read a very interesting report of the C.N.A. biennial meeting at Winnipeg.

Miss Bertha Birch spent the month of November at her home in Chatham, Ontario, convalescing after an appendectomy.

Miss Ruth Leavitt and Miss Kathleen Cunningham have gone to Rochelle Centre, Long Island, N.Y., where they will engage in private duty nursing.

Miss Elsie Brain has returned to Montreal from her home in Newfoundland. She will engage in private duty nursing.

Miss Mabel Robinson visited in Montreal in October.

Miss Margaret McCallum has accepted a position on the staff of the X-Ray department of the Ottawa Civic Hospital.

Jeffery Hale's Hospital, Quebec: At the annual meeting of the Jeffery Hale's Hospital Nurses Alumnae Association, Miss E. Armour, of the Class of 1921, was elected president.

The members of the Alumnae Association of the Jeffery Hale's Hospital offer their deepest sympathy to Mrs. Shreves in the death of her father, Mr. Frank Glass, of Quebec City.

The Alumnae is very pleased to hear that Miss F. L. Imrie has recovered from a recent operation, and is again on duty.

## VICTORIAN ORDER OF NURSES

Miss Marcelle Smith (Victoria Hospital, London), has been transferred from Brampton to Burnaby, B.C., of which district she will have charge. Miss Edna Clarke (Brantford General Hospital), takes Miss Smith's place in Brampton.

Miss Mabel Johnston (North Bay Hospital), has been granted leave of absence from Cobalt, during which time her place will be taken by Viola McFaul (Hamilton General Hospital.)

Miss Lillian Wixon (Grace Hospital, Toronto), has been transferred from the London staff to Hamilton.

Miss Aileen McKinnon (Women's College, Toronto) has been appointed to the staff in Hamilton.

Miss Grace Versey (Cook County Hospital, Chicago) has been appointed to the staff in London.

Miss Ellen Linton, of North Bay, has been granted three months leave of absence.

Miss Bessie Sweeny (St. Luke's Hospital' Ottawa) replaces Miss A. Labelle in Pembroke. Miss Labelle has accepted a position in the operating room of the Ottawa General Hospital.

Miss Martha Twiddy (Moose Jaw General Hospital) has been transferred to take charge of the new district of Oliver, B.C. Miss Catherine Haslam replaces Miss Twiddy in Trenton.

Miss Anne Goshko has been employed temporarily as the second nurse in Saskatoon, Sask.

Miss Aileen Leduc (Notre Dame Hospital) has been appointed to the staff at Lachine, P.Q.

The nurses who are at present taking the short intensive course offered by the Victorian Order at two of their centres, Halifax and Montreal, are: Montreal—Misses Margaret Clements (Ontario Hospital), Mary Cochrane (Rockwood Hospital), Dorothy Driffield (Montreal General Hospital), Derinda Ellis (Children's Memorial Hospital), Grace Whiessiel (Ottawa Civic Hospital); Halifax—Misses Ellen Hivey (Yarmouth Hospital), Dora Ashkins (Jersey City Hospital), Faye Saunders (Anna Jacques Hospital), Amy Holden (Victoria General Hospital).

## BIRTHS, MARRIAGES AND DEATHS

### BIRTHS

BRESSEE—On January 28th, 1928, at Delta, to Mr. and Mrs. Wm. Bressee (Ethel K. Brown, Kingston General Hospital, 1922), a daughter (Phyllis Evelyn).

CHOWN—On April 25th, 1928, at Renfrew, to Mr. and Mrs. S. Murray Chown (Laura Durbnow, Kingston General Hospital, 1921), a son (William Edwin Stanley).

CLELAND—At Oregon City, Oregon, October 17th, to Dr. and Mrs. John Cleland (Beatrice Eastmure, Royal Victoria Hospital, 1925), a son.

ERICKSON—On October 21st, 1928, at Haileybury, Ont., to Mr. and Mrs. Carl Erickson (Belle G. Taylor, Grace Hospital, Toronto, 1922), a daughter (Nancy Helen).

GODWIN—On July 22nd, 1928, at Kingston, to Mr. and Mrs. Wm. Godwin (Dorothy Garner, Kingston General Hospital, 1925), a daughter.

GRAHAM—To Dr. and Mrs. Wilfred Graham (Agnes Irwin, Hospital for Sick Children, Toronto, 1918), July 25, at Vancouver, B.C., a son (Duncan Lamont).

JENSEN—On September 24th, 1928, at Ilorin, Nigeria, to Mr. and Mrs. C. P. Jensen (Ina Mather, Hamilton General Hospital, 1918), a daughter.

McLEOD—To Mr. and Mrs. Peter McLeod, of Eylehart (Zetta Pratt, Hospital for Sick Children, Toronto, 1923), in June, a son.

McNAB—At Montreal, October 18th, 1928, to Mr. and Mrs. S. D. McNab (Brenda Eaton, Royal Victoria Hospital, 1913), a son.

MINGIE—At Montreal, November 3rd, 1928, to Dr. and Mrs. Walter Mingie (Olive Potter, Royal Victoria Hospital, 1919), a daughter.

MURRAY—At Montreal, November 2nd, 1928, to Mr. and Mrs. Murray (Claire Mitchell, Royal Victoria Hospital, 1924), a son.

O'BRIEN—At Montreal, October 28th, 1928, to Mr. and Mrs. E. O'Brien (Carrie Lucas, Royal Victoria Hospital, 1918), a daughter.

PLEWES—At Brantford on October 6th, 1928, to Dr. and Mrs. Franklin Plewes (Annie Bishop, Hamilton General Hospital, 1927), a daughter.

RAYMOND—On August 1st, 1928, to Mr. and Mrs. Gladsome Raymond (Mary Shuttleworth, Hospital for Sick Children, Toronto, 1924), a son.

SMITH—On October 17th, 1928, at North Battleford, Sask., to Mr. and Mrs. A. W. Smith (Robena Turnbull, Saskatoon City Hospital, 1924), a daughter (Eleanor Hope).

WINDLE—Recently at Holy Cross Hospital, Calgary, to Mr. and Mrs. Michael Windle, Okotoks (Susan Bella, Holy Cross Hospital, Calgary), a son.

### MARRIAGES

BARLOW—HULEK — At Hamilton on October 27th, 1928, Eva E. Hulek (Hamilton General Hospital, 1924), to Norman Barlow, of Hamilton.

BENNETT—PENMAN — On June 16th, 1928, at Kingston, Claire Ellen Penman (Kingston General Hospital, 1925), to Dr. Clifford Wesley Bennett.

BOSWELL—SMITH—On September 1st, 1928, at Cataraqui, Phoebe L. Smith (Kingston General Hospital, 1928), to Edward Boswell.

BROWN—ROBINSON—At Toronto, on September 17th, 1928, Constance Louise Robinson (Grace Hospital, Toronto, 1928), to Edward Brown of Port Hope, Ont.

BULL—WALLACE — Recently, at Fort William, Wilma Wallace (McKellar Hospital, 1927), to Dr. R. C. Bull. At home, Fort William.

CAINE—FEENEY—In July in Montreal, Marie Feeney (Montreal General Hospital, 1925), to Murray Caine, of Chicoutimi, P.Q.

CHADWICK—AMBLER — On Thursday, September 20th, Elizabeth Ambler (Hospital for Sick Children, Toronto, 1922), to Edward Chadwick, of Toronto.

CLARK—McMONAGLE—On June 8th, 1928, at Trenton, Miranda McMonagle (Kingston General Hospital, 1925), to Dr. Alexander Clark.

DEVERALL—SQUIRES — On October 26th, at Toronto, Dona Elizabeth Squires (Toronto Western Hospital, 1919), to Captain E. V. Deverall, Toronto.

ENRIGHT—WARD — On October 24th, 1928, at Saint John, N.B., Gertrude Ward (Saint John Infirmary, 1924), to Thomas Enright, of Saint John.

FARMER—CAMPBELL — In September, 1928, Margaret Campbell (Ottawa Civic Hospital, 1926), to Evans Farmer.

GIBSON—KELUSKY—On September 11, 1928, at Bancroft, Vereen Vivian Kelusky (Kingston General Hospital, 1927), to Dr. Sterling Gibson.

GILLIES—DOBBIE—In July, at Lachute, P.Q., Margaret Grace Dobbie (Montreal General Hospital, 1925), to Dr. James N. Gillies.

GOLDRING — TAYLOR — On October 20th, Florence Taylor (Hospital for Sick Children, Toronto, 1921), to Rev. A. J. Goldring. At home, Lindsay, Ont.

GRANT—WITHENSHAW — Recently, at Fort William, Hilda Withenshaw (McKellar Hospital, 1926), to Roy Grant. At home, Fort William.

HAMEL—MARRIOT—On September 1st, 1928, Gladys Marriot (Kitchener-Waterloo Hospital, 1923), to Emanuel Hamel.

HUMPHRIES—DENNISON — On Saturday, October 13th, Mayme Dennison (Hospital for Sick Children, Toronto), to Harold Humphries, of Carleton Place, Ont.

LAPP—NICHOLLS — On October 4th, 1928, at Uxbridge, Kathleen Nicholls (Kingston General Hospital, 1920), to Philip Lapp.

LOCKWOOD—MOTTO—On October 11th, 1928, Jean Kathleen Motto (Winnipeg General Hospital, 1926), to Wallace Lockwood. At home, Chaplin, Sask.

LOCKETT—WESLEY — On July 10th, 1928, at Brockville, Isa Wesley (Kingston General Hospital, 1927), to Edgar Lockett, B.A.

McPHERSON—KELLY—At Calgary, October 31st, 1928, Gladys Kelly, R.N. (General Hospital, Calgary), to A. McPherson, of Calgary.

MACKLIN—HILL—On July 6th, 1928, at Toronto, Ethel Agnes Hill (Grace Hospital, Toronto), to Frederick T. Macklin.

MASSON—LYALL—At Rochester, Minn., U.S.A., on October 20th, 1928, Laura May Lyall (Grace Hospital, Toronto, 1924), to Dr. Duncan Morrison Masson, of Rochester, Minn.

MILLER—POLLOCK — At Kincardine, Ont., September 22nd, 1928, Ruby Lillian Pollock (Kitchener-Waterloo Hospital, 1923), to Roy B. Miller.

MOORE—CUMMINGS—On October 20th, 1928, at Brandon, Helen Cummings (Brandon General Hospital, 1919), to Harold Moore, Regina.

MORRISON—MYLES — On July 19th, 1928, at Moncton, N.B., Grace Evelyn Myles to Roderick Morrison, of Everett, Mass.

NEATE—STEWART—On September 12, 1928, at Howick, P.Q., Julina Stewart (Montreal General Hospital, 1924), to Arthur Neate, of Montreal.

PENTECOST—HENRY—At Toronto, on October 20th, 1928, Jean Isobel Henry (Grace Hospital, Toronto, 1927), to Dr. Reginald S. Pentecost. At home, 143 Inglewood Drive, Toronto.

PETCH—BERLETT — At Kitchener on September 1st, 1928, Viola Berlett (Kitchener-Waterloo Hospital, 1925), to Russell Petch.

PIERCE—JUDSON — In August, Doris Judson (Montreal General Hospital, 1927), to Dr. Harry Hammond Pierce.

PTOLEMY — PANABAKER — At San Diego, California, September 1st, 1928, Anna Catherine Panabaker (Kitchener-Waterloo Hospital, 1922), to David Allan Ptolemy.

ROUGHTON—AGNEW — On September 25th, 1928, at Winchester, Lillian Gardner Agnew (Kingston General Hospital, 1927), to Donald Rattray Roughton, B.Sc.

SMITH—MOUNTEER—In June, 1928, at Kingston, Agnes Mounteer (Kingston General Hospital, 1927), to Charles Smith.

STEWART—BARNES—On August 18th, 1928, at Montreal, Edna A. Barnes (Montreal General Hospital, 1922), to Donald L. Stewart.

STEWART—KEMP—On October 20th, 1928, at Toronto, Laura Edna Kemp (Toronto Western Hospital, 1925), to Dr. Donald H. Stewart, of Hamilton, Ont.

SULLIVAN—JARVIS — On June 29th, 1928, at New York, N.Y., Hilda May Jarvis (Kingston General Hospital, 1927), to Thomas J. Sullivan.

WILSON—BARLOW—On September 1st, 1928, at Belleville, Bertha Irene Barlow (Kingston General Hospital, 1926), to Robert Foster Wilson.

WILSON—CAVELL—On September 21st, 1928, at Toronto, Katherine M. Cavell (Toronto Western Hospital, 1922), to Harold Wilson, of Toronto.

**DEATHS**

CLARK—In October, at the Rectory, Kate Smith, graduate of Montreal General Hospital, wife of the Reverend Charles Clark, of Belleville, Ont.

HAY—At Jefferson Hospital, Jefferson, Iowa, April, 1928, Elizabeth Hay, of Grand Junction, Iowa (Winnipeg General Hospital, 1913).

MILLAR—On Thursday, September 27th, 1928, at Grace Hospital, Toronto, Mrs. Robert Millar (Ethel McLennon, Grace Hospital, Toronto, 1915).

WILLIAMSON—On October 21st, 1928, in New York, Janet Mary Williamson, R.N., M.M. (C.A.M.N.S.; Lady Stanley Institute, Ottawa, 1912).

**BRITISH COLUMBIA GRADUATE NURSES ASSOCIATION**

An examination for the Registration of Nurses in British Columbia will be held January 23rd, 24th and 25th, 1929, in Vancouver and Victoria Centres only.

Names of candidates must be in the office of the Registrar not later than December 23rd, 1928.

Full particulars and instructions may be obtained from

HELEN RANDAL, R.N., Registrar,
125 Vancouver Block, Vancouver, B.C.

**BOOKS RECEIVED**

**Essentials of Medicine:** A text book of medicine for students beginning a medical course, for nurses, and for all others interested in the care of the sick. By Charles Phillips Emerson, M.D., and Nellie Gates Brown, R.N. Illustrated by the authors; 8th edition revised and reset. J. B. Lippincott Company, Philadelphia, London, and 201 Unity Bldg., Montreal, P.Q. Price $3.50.

Frontier Nursing Service has positions for public health nurses who hold the certificate in midwifery of English, Scotch or Irish Central Midwives' Board. For particulars, address the Director, Mrs. Mary Breckinridge, Wendover, Leslie County, Kentucky.

## *International Council of Nurses*

The Committee on Arrangements for the Congress 1929 has opened an office in the Royal Victoria Hospital, Montreal. Nurses who are planning to attend the Congress are requested to send their application for accommodation to the Committee at an early date. Members of the Canadian Nurses Association are reminded that by making early application they shall greatly aid the Committee which has to assume the responsibility for all arrangements in connection with the Congress in addition to making satisfactory plans for the housing of large numbers of guests.

Rooms have been secured in hotels, convents and boarding houses at rates varying from $1.00 to $5.00 per day. The rates for rooms in the large hotels are as follows:

| | |
|---|---|
| Single room | $3.00—$ 4.00 |
| Single room, with bath | 5.00— 7.00 |
| Double room | 5.00— 7.00 |
| Double room, with bath | 8.00— 10.00 |
| Large room, 3 persons | 7.50— 10.00 |
| Large room, 4 persons | 8.00— 12.00 |

Rates for bed and breakfast in convents are from $1.25—$1.50.

Rates in boarding houses vary according to location and accommodation offered.

On arrival in Montreal visitors are requested to report to Headquarters —The Montreal High School, University St., for room assignment.

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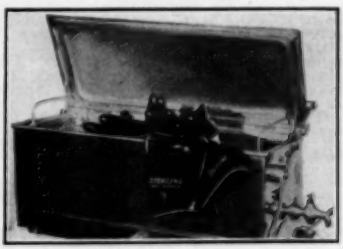

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Talk No. 6

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